State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 14 **Physician** February 2006 1:45 A M DiBenedetto Angelo Anthony /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner California St. Mary's 23600 Gross Drive If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12-3-1913 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 € M 2 🗆 F New York 054-01-2865 92 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: if Item 27 is marked other than "natural", or Itame 23e or 28e-f ahow try or other treamatic avent, I'm Medical Exercipational transities and Itam. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No Director St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23600 Gross Drive 20619 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ■Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify: Specify: ģ 3 ■ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DiBenedetto Angelina DiGregorio 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela E. Edwards / Daughter 23600 Gross Drive California, Maryland 20619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State N Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Immaculate Heart Mary 2/18/2006 Lexington Park, MD. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01206 22955 Hollywood Road, Leonardtown, MD 20650 Kyle S. Simons 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bronchogenic Carcinoma Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consultience of Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed be should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Coronary artery disease 1 Yes 24 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No 1 Yes 1 ☐ Yes 2 🕅 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending 5 Pending Injury within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 Yes 2 No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 14,2006 DU 2159 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20621 Mazzo, M.D., Maryland Infirmary, Chaptico, Maryland 31. Date filed (Month, Pay, Year) FEB 1 5 32. Resistrar's Signature 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Florence Carson Donaghy February 6, 2006 8:45 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Manor Healthcare Center Rising Sun Cecil If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days 1 ☐ M 2 🖾 F Months Hours 80 Director 167-38-0087 Nov. 1925 20, Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is markad other than "naturel", or itams 23a or 28a-f show treumatic evant, the Medical Examiner must be notified at 1 Tyes 2X No Director Maryland Cecil Conowingo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 878 Dr. Jack Road 21918 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. 72 hours after ☐ Yes 2 X No Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify þ 3 Midowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Twelve Years Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fii of Health and Mental H f i**tam 27 is markad** otl Be James W. Carson Florence G. Aplin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Quinn (Daughter) 878 Dr. Jack Road, Conowingo, Maryland 21918 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of important: if it eny injury or o ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oakland Cemetery * 4 □Donation 5 □ Other (Specify) 02/10/06 Philadelphia, Pennsylvania 21. Sign Jure of Funeral Service Licenses 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. OX. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HIzheimer's 2-3 years Physician Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Guisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed use as the burial-transi Due to (or as a consequence of): Box 68760, the attending physician ian/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day Year Month Physici 4 Pregnant at time of death 5 Other (specify) P.O. I Yes 2 No 9 Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ξ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? page certificate 2X No 1 Yes Physicien: director Be 25. Was case referred to medical 26. Place of Death_(Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Atlanding. After 1 Natural 5 Pending within 24 hours after death.

To the Funaral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide determined the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c License number D00 59354 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil Lattin, M.D., 101 Colonial Way, Suite A, Rising Sun, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

	4		1 - For State Registrar Amend#2	9d.PerP		f Marylar 2–9–06cr		artment			and M	-	giene Reg. No.	006	05503	
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Divisio		ertification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	M 1]Yes 2□No	28f. Location City or To	(Street and Numb wn, State)	er or Rural Route Number,
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,	(5)		30. Name and address of person who of				MD 2110			uary 7, 2006
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Amend item#5, perffl, 353,3/3/00 III Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiepe Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 6:30P M 02 06 06 /Medical Eugenie Duncan 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Bethesda Health & Rehabilitation Ctr. Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Nu 216-60-2099 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔂 F 80 Hours Director 262-60-2099 07 02 Trelawny, Jamai Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show 10d. Inside City Limits the Medical Examinar must be notified at tx☐Yes 2☐No Director Washington D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death 20011 USA Funeral 821 Webster St. N.W. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a nad Mental Hygiene. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Black þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1 yr. Nurse D.C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev 2008. Adolphus Mitchell 2 Eliza Cadian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vinette Walker/Daughter 816 West Side Dr. Geithersburg, MD. 20878
se of Disposition (Name of Date Date Doc. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) George Washington 2-11-06 Adelphi, MD. 22. Name and Address of Facility MArshall's Funeral Home 21. Signature of Funeral Service Licensee Markall 4217 9th. St. N.W. Washington, D.C. 20011 23a. Part Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hepatitis C /Medical Due to (or as a consequence of) Examiner Cirrhosis of Liver Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Pelvic Mass Due to (or as a consequence of): Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Day Year 4 Pregnant at time of death 5 Cther (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 Tes 2X No 3 Probably 4 Dunknown Completed Gastritis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 2**X** No 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 2 1 ☐ Yes 2 🛣 No this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death, 1 ☐ Yes 2 ☐ No investigation М 2 Accident within 24 hours after death to the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and 29d. Date signed (Month, Day, Year) 29c. License number D53091 Feb. 9, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Reddy, MD. 6320 Democracy Blvd., Bethesda, MD. 20817 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

FEB 1 0 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9,2006 Month **Physician** 8:55 AM JANE ELSIE DEAN February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Lutheran Home Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2√□ F 89 217-24-7906 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28e-f show idical Exprisive must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701 Veirs Drive 20850-3462 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Operated Concession Stand other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fi Wilford Jacob Dean Grace Inez Clopper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 an 1009 Columbia Road, Hagerstown, Maryland 21740 C. Robert Dean Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Fairview Cemetery 02-13-06 Keedysville, Maryland 1 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. 23a. Part1. Enter the disease, or complications let caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 40 East Antietam Street, Hagerstown, Maryland 2174 Approximate Interval Between Mon Ins Immediate Cause (Final disease or condition resulting in death) **Physician** Ling /Medical Examiner cors Lee 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner requires that the death certificate be executed Lari Due to (or as a consequence of) burialattending physician Completed by Physician/Medical the as use 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2 No P.O. detached the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. þe disease. Ser 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? neumonia 24a. Was an page 2 autopsy 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this luneral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled Hospital within 24 hours a 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Charles W.

31. Date filed (Month Day,

ORIGINAL

Veirs

9701

Registrar's Signature

Karesh MD,

Drive, Rockville, Maryland 20850

	d	item #2 per dr/wicl	nd/2-14-2006/	11s Certiti	cate or	Death		Reg. No.	0 0000
		1. Decedent's Name (First, Middle, Last)				2. Dete of De Month		3. Time of Deat
Physicia /Medic		Leslie James Dav	idson				Februa	. 0	
Examin		4a Fecility Neme (If not institution, give				4b. City, Town, or Lo	ocation of Deat	4c. County o	f Death
		Peninsula Regiona	l Medical Cen	ter	5	Salisbury		Wicomio	0
Funeral		Sociel Security Number 6. Se	x 7. Age (In yrs.	last birthdey) If Mo	Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	 Birthplece (State or Fore Country)
Director		221-14-2229	XM 2□F 77	Yrs.			10/11		Delaware
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No.	Ē	10e. Street end Number			of. Zip Code			10g. Citizen of Wi	nat Country?
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er de	un.	11. Maritel Status	12. Was Decedent Ever in U Armed Forces?	,S. If Yes	, specify Cub	lispenic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black	, White, etc.
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hour Fig.	Completed by	Δ		16e. Decedent's	Lleual Occur	pation		16b. Kind of Bus	
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DHMH 16 Rev 6/95

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Physician /Medical	John	Gerard			Di (Cris	spinc)	Februa			006	2:30	Α ^N
Examiner	4a. Facility Name (If not instit	ution, give street and numb	ber)		4b. City, To	wn, or	Location (of Death		4c.	County o	f Death		
		ay Apartment			Annaj			0411	,		nne A			
Funeral	5. Social Security Number	6. Sex 7.	. Age (In yrs. I	last birthday) Yrs.	Months [Days	If Under Hours	Min.	8. Date of Bir (Month, Da	y, Year)		Coun		or Foreig
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ner then "nature it, the Medical E Completed	15. Deci (Specify onfy h	edent's Education ighest grade completed)		16a. Deced (Give)	ent's Usual (kind of work of OO NOT use	Occupa done d	tion uring mos	t of work	ing	16b. Ki	ind of Bus	iness/Ind	dustry	
m dr	Elementary/Secondary (0-	12) College (1-4	4or 5+)		nbly W					Zλs	ssemb	olv		
S I	12 17. Father's Name (First, Mic	Idle. Last)		710001	mary III			ar's Nam	e (First, Middle,					
c even			Crisp	ino				icia					ristie	1
marke To	19a. Informant's Name/Rela		CI IDP.		a Address (S	Street a			al Route Numb	ar. City o	r Town. S	State. Zip	Code)	
trau		Crispino -	Father										,	
othe	20a. Method of Disposition	CITOPINO	20b. P	lace of Dispos	sition (Name	of			Date				wn, State	
y or	1 Burial 200 Cremate 4 Donation 5 Other	ion 3 Removal from St	iaie	emetery, crem las Cre			9)	2/2	1/2006	Edae	ewate	er. N	/ID	
injura	21. Signature of Funeral See		100		Name and		s of Facili		1					
d y a	Henl	Roll		G	gggge	P.	Kalas	Fur	neral Ho	ome,	P.A.	ir N	1D 210	137
	23a. Pant. Enter the diseas	e, or complications that cau	used the death								Ewale	1	Approximat	te
sician	tmmediate Cause (Final	List only one cause on eac		D.									Intervat Bet Onset and Week	Death
dical	disease or condition resulting in death)		ras a consequ	iver Di	isease							-) week	
niner			itis 1										years	;
je je	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	rasa consequ	uence of):										
Examiner	that initiated events	С												
LEX Crial	resulting in death) Last	Due to (or	ras a consequ	uence of):										
the burial-transit		d												
Physician/Medical	IF FEMALE:	23c. If yes, outco	ome of pressor	DOM.	-									
detached for use	23b. Was decedent pregnan in the past 12 months?	1 ☐Live birt	th 2 ☐ Fetal nt at time of de	Ideath 3□	Ectopic preg						23d. Date Mont		•	Year
ched	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknow		5	Culei (Spec									
	Part II. Other significant cor	ditions contributing to dea	th but not res	ulting in the un	derlying cau	se give	n in Part I		23e. Did t	obacco u	use contri	bute to th	e cause of	death?
d by	Downs Syndr	rome							10	Yes 2	⊠ No ∶	3 🗌 Prob	ably 4 🗆	Unknov
cete hes been signe, page 2 should be completed by									24a. Was	an	24b W	ere auto	psy findings	availab
20 D									auto	psy ormed?	pr	rior to cor eath?	npletion of o	ause o
rector, pag	25. Was case referred to me	dical					00 01	1 D 1	1 Tes	2 2 No	1 [Yes	2 No	
his certifi il director To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Ing	nationt 2	ER/Outpatient	2000	Othe	-		h <i>(Check only o</i> ome 5 ⊠ Resi		s □Otho	r (Specifi		
eral dir	27. Manner of Death	28a. Oate of (Month,		28b. Time of		: Injury Work		arsing ric	28d. Describe				"	
led in by the funeral	1 Natural 5 ☐ Pe	ending (Month, vestigation	, Day Year)	Intury	м		:? ∕es 2 🗆	No						
d in by the fu		ould not be 28e. Place o	of tnjury - At ho	ome, farm, stre	et, factory, o	office			28f. Location (r or Rura	Route Nun	nber,
Serie Series	4 - Homelde	Dullang	g, etc. <i>(Specif</i>)	7)					City or To	WII, SIAIC	"			
To the Funerel Director: Attenthis certificate in completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier 12 Cert (Check only 2 Med	ifying Physician: To the b	est of my kno	wledge, death	occurred at	the tim	e, date ar	nd place,	and due to the	cause(s)	and man	ner as st	ated.	->
To the Funerel Completely filled Medical Ce	one)	ical Examiner: On the bas and manne	or stated.	tion and/or inv	estigation, in	n my op	inion, dea	ith occur	red at the time,	date and	piace, a	na aue to	tne cause(5)
2 00	29b. Signature and title of ce	rtifier \/	2+				number				_		Day, Year)	
	Mech	10	un Cq	M	D2	2143	8			repr	uary	21,	2006	
	30. Name and address of pe	son who completed cause	of death (Item	23a) (Type, F	Print)									
1		a Penta, M.D	445	Defense	High	way	, Anr	apo	lis, MD	2141	71			
State	31. Date fited (Month, Day,)	ear) 32. Rec	gistrar's Signa	ture	_	-	•		,	(· ·			

cian	1 - For State Registrar 1. Decedent's Name				Certificate of	f Death	2. Date of De	Day	Year	3. Time of Death
ical iner	4a. Facility Name (I	AN M. EN f not institution, g HILL MA	ive street and num	ber)		or Location of C		4c. C	2006 County of Death	5:25PM
1	5. Social Security N 219-12-2	637	. Sex 7 1 ☐ M 2 ☐ X F	. Age (In yrs. last 82	birthday) If Under 1 Ye Yrs. Months Da		Min. B. Date of Bil (Month, De DEC 8)	1923	9. Birthp Cour NEW	place (State or Fore htry) ORK
tor	Usual Residence of 10a. State	10b. County	LBOT		own or Location				1	0d. Inside City Lin
Funeral Director	10e. Street and Nur				10f. Zip Cod	21647		10g. Citize	en of What Cour	ntry?
by	11. Marital Status	ied 2 Married	12. Was Deced Armed Ford	No No	13. Was Decedent of If Yes, specify C	of Hispanic Origin uban, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)		4. Race - Americ Black, White,	
Completed	Elementary/Seco		grade completed) College (1-		6a. Decedent's Usual Oc (Give kind of work do life. DO NOT use rei	ne during most o ired)	f working		d of Business/In	
Be	17. Father's Name			1	SECRETARY	18. Mother's	Name (First, Middle	, Maiden S		JFACTURII
7	19a. Informant's Na		(Туре, Print)	1	19b. Mailing Address (Str.	et and Number		er, City or		
		Cremation 3 5 Other (Spe		CHESA	e of Disposition (Name of etery, crematory or other) APEAKE CREMA 22. Name and Ad FILOWS 200 S. 1	TION CT	Date R 2/9/2006 BEIN & NEW ST EASTON	5 ST		LE, MD
ler	23a. Part 1. Enter to shock, or head Immediate Cause disease or condition resulting in death) Sequentially list contains, leading to ficause. Enter Under	nt failure. List on (Final in nditions.	aDue to (o	used the death. I ch line. Con line. Con line as a consequent as a consequent	ce of):	tying, such as ca	rdiac or respiratory a	arrest,		Approximate Interval Beyeer Onse, any eat
Medical Examine	Cause (Disease or that initiated events resulting in death) I	injurý 3	c Due to (o	r as a consequen	ce of):					
Physician/N	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 20 9 Unknown	months?	1 Live bir	ome of pregnancy th 2 Petal de nt at time of death vn	ath 3 Ectopic pregna			23	3d. Date of delive Month	ary Day Year
by	Part II Other signif	- 1	contributing to dea	ath but not resultin	ng in the underlying cause	given in Part I.		tobacco us Yes 2		he cause of death pably 4 DUnkn
Completed							24a. Was auto perf 1 \(\text{Yes}		24b. Were auto prior to co death? 1 Yes	psy findings avai mpletion of cause 2 No
Be	25. Was case refer examiner?	red to medical	Hospital:			Other	f Death (Check only			
tlon: To	1 ☐ Yes 2 X 27. Manner of Deat 1 ☐ Natural	-	28a. Date of (Month		b. Time of 28c. In Injury	Other: 4 Nurs. njury at Vork? Yes 2 No	ing Home 5 Res 28d. Describe			y)
Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not determine	be 28e. Place	of Injury - At home g, etc. <i>(Specify)</i>	a, farm, street, factory, offi		28f. Location	(Street and wn, State)	Number or Rura	al Route Number,
	29a. Certifier (Check only one)			sis of examination	dge, death occurred at the and/or investigation, in m					
edical			1 1-1		29c. Lic	ense number		29d. Date	signed (Month,	Day, Year)
Medical	29b. Signature and	title of certifier	alle	mo	D	3528	4	2/	9/06	
Medical		Il The	io completed cause	of death (Item 23) O 26 gistrar's Signature	Ba) (Type, Print) 95. Crashy	3528	4 Basfn	of n ma	9/06	0/

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State of Registrar	Maryland / D	epartme Certifica			_	giene Reg. No.	006	05510
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Year	3. Time of Death
	/Medio		Esther Eck	man				Februa			2225 M
	Examir	er	4a. Facility Name (If not institution, give street and num		4b. Cit		Location of Death	ו	4c. C	County of Dea	th
			Calvert Manor Healthcar		t t litter	Ris er 1 Year	ing Sun	T =			cil
	Funeral		5. Social Security Number 6. Sex 160-16-6793 1□ M 2⊠F	'. Age (In yrs. last birt 87	Yrs. Months		Hours Min.	(Month, Da	Birth 9. Birthplace (State or Foreign Country) 3, 1919 Pennsylvania		
	Director		Usual Residence of Decedent	87				Jan. 3	, 191	.9 F	ennsylvania
	yland		10a. State 10b. County	10c. City, Town	or Location						10d. Inside City Limits
	Mar	tor	Maryland Cecil			Con	owingo				1 ☐ Yes 2X No
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hyglene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Madical Examinatings be rollised at	Funeral Directo	10e. Street and Number		10f. 2	ip Code			10g. Citize	en of What C	ountry?
	238 c	a	39 Eckman Lane			2	1918			U.S	.A.
	dea	ner	11. Marital Status 12. Was Deceder Armed For	lent Ever in U.S.	13. Was Dec	edent of Hi	ispanic Origin? (S n, Mexican, Puert	pecify Yes or No	- 14	4. Race - Am	
98	or it	/Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	2 ⊠ No		2 K No		o moan, sto.)		Specify:	e, etc.
215-0036	ural',	d by	3 Wildowed 4 Divorced Year or Da	tes:						эрвспу.	White
7	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Us (Give kind of w life. DO NOT	rork done d	durina most of wor	rking	16b. Kin	d of Business	/Industry
212	withly ene. then	щ	Elementary/Secondary (0-12) College (1- Twelve Years	4or 5+)		emake			D-		Danidon
d 2	filled Hygin ther	ပို	17. Father's Name (First, Middle, Last)		- 11011	remare		ne (First, Middle,			Residence
an	d be ental	o Be	George Harvey 1	rv				Attie		,	
Maryland	shoul nd Me mark	은	19a. Informant's Name/Relationship (Type, Print)		Mailing Addre	s (Street a	and Number or Ru				Zin Code)
S S	od 2 :						Rising Su		_	21911	
ō	tem tem othar		20a. Method of Disposition	20b. Place of	Disposition /N	ame of		Date Date		ation - City or	
9	ages ent of the H i		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from S 14 ☐ Donation 5 ☐ Other (Specify)	tate Litt Presbyt	y, crematory or le Bri	other place	e)	14/06	Fulto	n Two.	Pennsylvania
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours Department of Heelth and Mental Hyglene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Madical Exa once.		21. Signature of Funeral Service Licenses	Flesbyt	22. Name	and Addres	ss of Facility				
ä	Depa Impo any in		Shon Tes. N. ATTHOSD	no or.			terson & , Maryla				P.A.
			23a. Part1. Enter the disease, or complications that ca	used the death. Do n						00	Approximate Interval Between
T.	Physician		shock, or heart failure. List only one cause on ea	ch line.		7					Onset and Death
7	/Medical		disease or condition resulting in death)	r as a consequence of	off.	Den	nentia_				6 & hours
	Examiner			, , , , , , , , , , , , , , , , , , , ,							
	n 2	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	r as a consequence o	of):						
	ate be executed obysician and the burial-transit	Examiner	that initiated events C.								
0,	e exe ian a urial-	Ĕ	resulting in death) Last Due to (c	r as a consequence of	of):						
8760,	ate b hysic the b	lical	d								
9	e as	Mec	IF FEMALE:								
Box	ath co	an/	23b. Was decedent pregnant 1 Live bit	ome of pregnancy th 2 Fetal death	3 □Ectopic				23	3d. Date of de Month	livery Day Year
_	The law requires that the death certificate be executed tie has been signed by the ettending physician and otge 2 should be detached for use as the burial-transit	Physician/Med	1 ☐ Yes 2 ☑ No 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unknown	nt at time of death vn	5 Other (specify)				THO ILL	Day Toll
P.0.	that the sed by detac		Part II. Other significant conditions contributing to dea	ath but not resulting in	the underlying	Cause day	en in Part I	23e Did t	ohacco us	e contribute t	the cause of death?
Records,	sign of be	Completed by	ρ		and and only and	oadso give	on mir une i.				robably 4 □Unknown
ò	w requir been si should	ete	Expressive Aphusia	···-				-			
3e	The law cate has pege 2.3	Пр	Depression					24a. Was autop		24b. Were a prior to death?	topsy findings available completion of cause of
a								1 ☐ Yes	2 D No	1 Tes	2 □ No
of Vital	Physician: r this certifica ral director, i	Be	25. Was case referred to medical examiner? Hospital:			Othe	or.	ath (Check only o			
of	Phys r this ral dii	7	1 ☐ Yes 2 ☑ No ☐ Hospital: 1 ☐ In 27. Manner of Death 28a. Date or	patient 2 ER/Out		NOA _	4 Wursing F	lome 5 Resi			city)
on	ding far. After funera	tlon	1 ☑Natural 5 ☐ Pending (Month 2 ☐ Accident investigation		njury M	28c. Injury Work	k? Yes 2 □ No	Edd. Describe	now inquiry	Occurred	
Division	Attending or death. ector: After by the fune	flca	3 Suicide 6 Could not be 28e Place	of Injury - At home, far				28f. Location (Street and	Number or R	ural Route Number,
Di	effer Direction of in b	Certification:	4 Homicide determined buildin	g, etc. (Specify)		7,		City or To			
	pepita hours inera y fille	<u>a</u>	29a. Certifier 12 Certifying Physician: To the	pest of my knowledge	, death occurre	d at the tim	ne, date and place	, and due to the	cause(s) a	and manner a	s stated.
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	edical	(Check only one) 2 Medical Exeminer: On the bar and mann	sis of examination and	d/or investigation	n, in my o	pinion, death occu	irred at the time,	date and p	place, and du	e to the cause(s)
	To t Com	Ž	29b. Signature and title of certifier	\	2	9c. License			29d. Date	signed (Mon	h, Day, Year)
•			Farm K. Werdre	r JR.m		DO	244373		2	01	2006
	10		30. Name and address of person who completed cause	of death (Item 23a) (Type, Print)						
	12		Joseph K. Weidner, Jr.,	M.D., 101	Colonia	ıl Way	y, Risin	g Sun, M	Maryla	and 2	L911
	Sta	te	31. Date filed (Month, Day, Year). 32.	gistrar's Signature	Soret	,					

Dharis	â	1. Decedent's Name (First, Middle, Last		Certific	cate of D	caui	2. Date of Dear Month	eg. No. th Day	Year	3. Time of Death
Physicia /Medic		Elaine V.	Emeth				February	6, 2006	5	12:25 a M
Examin	er	4a. Facility Name (If not institution, give	street and number)	4b.		ocation of Death		4c. Count	y of Death	
	÷.	931 Loxford Terrace 5. Social Security Number 6. S	ex 7. Age (In yrs.	last hirthday) If I	Silver Sp Under 1 Year	oring If Under 24 Hrs.	8 Date of Birth		ntgome:	
Funeral Director			□ M 2 🗗 57		onths Days	Hours Min.	8. Date of Birth (Month, Day May 25,	Year) 1948		place (State or Foreign ptry) cticut
MoL		10a. State 10b. County	10c. Cit	y, Town or Locatio	n				1	10d. Inside City Limits
Ba-f el	Funeral Director	Maryland Montgom	ery Silv	er Spring						1 ☐ Yes 24 ☐ No
a or 2	Dire	10e. Street and Number		ľ	0f. Zip Code 20901		1	0g. Citizen of	What Cour	ntry?
me 23	eral	931 Loxford Terrace 11. Marital Status	12. Was Decedent Ever in U			panic Origin? (Spe Mexican, Puerto	ecify Yes or No-		ce - Americ	
Department of Health and Mental Hygiene. Importent: or Items 23a or 28a-1 show Importent: If Item 27 is marked other then "natural", or Items 23a or 28a-1 show any injury or other treumatic event. It Medical Examinat must be notified at once.	þ	1 Never Married 2 XMarried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:			Mexican, Puerto Specify:	Rican, etc.)		ick, White, fy:White	
natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Decedent's (Give kind	s Usual Occupati of work done du IOT use retired)	on ring most of worki	ing	16b. Kind of 8	Business/In	dustry
iene.	фшо	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Pasto				United N	1ethodi	st Church
ked other	To Be C	17. Father's Name (First, Middle, Last) John B. Piescik		Tabec		8. Mother's Name		Maiden Suma		or and a
and N Is mail		19a. Informant's Name/Relationship (** *			d Number or Rura				c Code)
m 27 her tr		Daniel M. McCarthy,		10000		ce, Silver				
ment of H ent: If its ury or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State Wes	Place of Disposition cometery, cremator stminster C	ry or other place)	Febru	oate Jary 10, 106	20c. Location Westmins		
Depart Import any in		21. Signature of Funeral Service Licer	S 00			lins"tuner Blvd, W,			20901	
ysician Medical Mepnial-transit	cal Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any leading to kind additionable cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of): uence of):	rosis					Interval Between Onset and Death
g phys as the			_ d							
yy the attending physic ached for use as the b	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	il death 3 □Ecto	opic pregnancy ner (specify)				ate of deliv	ery Day Year
been signed by the should be detached	d by P	Part II. Other significant conditions of Chronic Urinary Tract	-	-		in Part I.	23e. Did to		ntribute to t	the cause of death? bably 4 []Unknowr
hes le 2	omplete						24a. Was a autop perfor	med?	deatn?	opsy findings available ompletion of cause of
	BeC	25. Was case referred to medical				26. Place of Deat		No No	1 🗆 Yes	2L NO
r this dertificanal director,	10	examiner? 1 Tes 2 Yo	Hospital: 1 Inpatient 2		DOA Other	4 Nursing no	me 5 Resid	ence 6 🗆 O	ther (Speci	fy)
, 1	atlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work? M 1 ☐ Ye	es 2 No	28d. Describe h	ow injury occu	irred	
within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fy)	factory, office		28f. Location (S City or Tow		ber or Rur	al Route Number,
e Funer	Medical	29a. Certifier 1 Lertifying Ph (Check only one) 2 Medical Example	nysician: To the basis of my kind niner: On the basis of examina and manner stated.	wladge, doath uco ation and/or investi	turned at the time gation, in my opi	date and place nion, death occur	and due to the or red at the time, or	ause(s) and n late and place	and due t	stated to the cause(s)
The Co	Me	29b. Signature and title of certifier	11/)		29c. License	number		9d. Date sign	ed (Month,	Day, Year)
₹ L 8		X / 1001	11/2 5		NL	11015		216	11	76
) \$ 4 <u>\$</u>					1 1 1	1	2	-/	<i>)</i> / C	20850

			1 - For State Registrar	State of Ma	ıryland	/ Depa	artment of F tificate of	lealth and N <i>Death</i>		ejne) () 6 g. No.	05513
200	Physici /Medic		Decedent's Name (First, Middle, Last)	Helen	Cathe	rine	Eyler		2. Date of Death Month February	Day Year 18 2006	3. Time of Death 2:00 P M
1 No. 2	Examir		4a. Facility Name (If not institution, give st 5933 Conover Road	reet and number)			Taneyto		-	4c. County of Deat	h
**	Funeral Director		5. Social Security Number 6. Sex 212–24–5825	7. Age	(In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 14	Year) Co	hplace (State or Foreign untry) ryland
	Maryland	tor	10a. State 10b. County Maryland Carroll C	ounty	10c. City, 1	Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 28	al Direc	10e. Street and Number 5933 Conover Road				10f. Zip Code 2178	37		g. Citizen of What Co Inited Stat	,
980	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Ie marked other than "naturel", or iteme 23s or 28e-f ehow other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent E Armed Forces? 1 Yes 25 N If Yes, Give Year or Dates:		'	Was Decedent of H f Yes, specify Cub I ☐ Yes 2 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
21215-0036	d within 72 h giene. er than "natu the Medical	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)			(Give life. l	lent's Usual Occup kind of work done DO NOT use retired DECTOR	during most of work	ring	6b. Kind of Business/ garment fa	,
aryland	uld be file Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last) Arthur B. Krug						e (First, Middle, M atherine		
Σ	and 2 sho ealth and I m 27 le mu		19a. Informant's Name/Relationship (<i>Typi</i> Mary Frances Selby		ter	5933	3 Conover	Road 1	Taneytown	City or Town, State, 2 , Maryland	21787
altimore,	permit. Pages 1 Department of H Important: If ite any injury or ott		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		cem	Pleas	sition (Name of natory or other place sant Ceme	etery Feb.	. 22 2006 T	oc. Location - City or aneytown,	
Ba	Depar Impor any in		21. Signature of Futeral Service Licensee	Lurra		13		altimore	Street	eral Home Taneytown,	
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused cause on each lin	e. Hc	Ste.	er the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Examiner and trensit	Examiner	Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Cua to (or se s	i donésquei	iou of):					
8760,	ficate be executed physicien and s the burial-trensit	dlcal	d.	Due to (or as a	consequer	ice or):					
.O. Box 6	law requires that the death certifi as been signed by the ettending 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	c. If yes, outcome of 1 Live birth 14 Pregnant at 9 Unknown	2 🗌 Fetal de	eath 3	Ectopic pregnancy Other (specify)	,		23d. Date of del Month	ivery Year
<u>a</u>	w requires that been signed b should be deta	by	Part II. Other significant conditions conti	ributing to death bu	it not resulti	ng in the ur	nderlying cause giv	en in Part I.		acco use contribute to	the cause of death?
Division of Vital Records,	The ste h page	Completed							24a. Was an autopsy perform	ed? prior to death? No 1 □ Yes	atopsy findings available completion of cause of 2 \(\simega\) No
Ξ	ysicia is certi directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:	nt 2 EF	VOutpatien	t 3 DOA Oth		th <i>Check</i> only one	nce 6 Other (Spe	cify)
sion o	Hospitel or Attending Physician: 24 hours after deeth. Funerel Director: After this certificately filled in by the funeral director.	Certification; 1	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		Bb. Time of Injury	28c. Injur Wor	y at	28d. Describe how		
DIX	oltel or Attendurs after deeth	Certifle	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	. (Specify)				City or Town,	·	
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine 2 Medical Examine	cian: To the best of er: On the basis of and manner state	examination	edge, death n and/or inv	r occurred at the tir restigation, in my o	pinion, death occur	red at the time, da	use(s) and manner as te and place, and due d. Date signed (Monti	to the cause(s)
	T.¥.T.⊗		1/1/2 11	(N	0		Doo	C 8/31	7	2/7 a/	, Jay, real)
_	7		30. plame and address of person who com	ipleted cause of de	eath (Item 2:	3a) (Type,	Print) Tie St	307	Westin	aster M	021157
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 4 2006	32. Registra	r's Signatur	Spend					1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

29d. Date signed (Month, Day, Year)

2. Date of Death Month 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** GEORGE HENRY ADDISON FISK II **FEBRUARY** 2006 4:15PM /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RAYLAND ACRES TRAPPE TALBOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JULY 2 1 927 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** FLORIDA 78 Yrs Director 267-32-9918 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Illimportent: if Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other treumstic event, the Mcdical Examinar must be neither anong. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes X No Director TRAPPE TALBOT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 29160 KRISMORE CT. 21673 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING PLANT MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALICE EUGENIA CHALKER ROY D. FISK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 28806 JASPER LANE, EASTON, MD 21601 ELIZABETH O. FISK/WIFE 20a. Method of Disposition
1 □ Burial 2 ☐ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State CHESAPEAKE CREMATION CTR 2/13/2006 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Joseph Ustrowshi C.F 21. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 12heiners BRELL /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-translt The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Lunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performe certificate 1 Yes 204 No Hospitei or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTED Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{\text{M}}\)Other (Specify) \(\text{LIVING} \) 1 ☐ Yes 2 🗷 No 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA funeral 28d. Describe how injury occurred 28b Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

29c. License number

State Registrar 29b. Signature and title of certifier

30. Name and address of person who

31. Date filed (Month, Day, Year)

04

completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

			1 - State C Registrar		artment of Health and M rtificate of Death	ental Hyglene Reg. No	OTOU OUU
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death A
	/Media	cal	MARY ELIZABETH F 4a. Facility Name (If not institution, give street and nu	OLEY	4b. City, Town, or Location of Death	FEBRUAR9	2 / 12 / 2006 1050 M
	Examir	ier	UNION HOSPI		ELKTON	40	CECIL
	Funeral Director		5. Social Security Number 181-09-8359 6. Sex 1	7. Age (In yrs. last birthday) 90 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year, Apr 22 19	9. Birthplace (State or Foreign Country) Pennsylvania
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	a-f sh	ctor	MD Cecil	Earlev:	ille		1 ☐ Yes 2 🙀 No
	or 28	Dire	10e. Street and Number		10f. Zip Code	10g. Ci	itizen of What Country?
	eath v	eral	12 Circle Dr. 11. Marital Status 12. Was Dec	edent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe		S . A . 14. Race - American Indian,
Maryland 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heath and Mental Hyglene. ortant: If item 27 is marked other than "natural", or Items 23a or 28a-1 show injury or other traumatic event, I're Modical Examinar r wat be recilied at ea.	Completed by Funeral Director	1 Nover Married 2 Married 1 Yes 1 Year or C Year or C	2 <mark>∑</mark> No ve	Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto if 1 ☐ Yes 2♥ No Specify:	Rican, etc.)	Black, White, etc. Specify: White
15-0	natu	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during most of workir DO NOT use retired)	16b. H	Kind of Business/Industry
121	filed within Hygiene. Ither than	duic	Elementary/Secondary (0-12) College (1-40r 5+)	lerk		armaceutical
pd 2	be filled ital Hygi d other event,	se Co	17. Father's Name (First, Middle, Last)			(First, Middle, Maider	
ylaı	should be and Mental is marked c	To Be	Joseph Foley		Elizabe	eth Welsh	1
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print)		•		or Town, State, Zip Code) 94117
	t and Health tem 27		John Foley (nephe				an Francisco, CA ocation - City or Town, State
Baltimore,	permit. Pages Department of I Important: If its any injury or o		1 🖫 Burial 2 □ Cremation 3 □ Removal from '4 □ Donation 5 □ Other (Specify) 21. Signature of Tone □ Priv Siden as	Old Bohe	emia Cem. 2/16,		rwick, MD.
B	Depa Impo any ir		1 the Oct	M00510 G	alena Funeral Ho 18 West Cross S	ome of St t. Galena	tephen L Schaech
	Physician /Medical Examiner	ier	resulting in death) Due to	ONGESTIV (or as a consequence of): RITICAL (or as a consequence of):	AURTIC ST	ENOSIS	Ś.
x 68760,	The law requires that the death certificate be executed tte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Medical Examiner	resulting in death) Last C. Due to	(or as a consequence of):	ARTERY DI	SEASE	
.O. Box	that the death cert led by the attendin detached for use a	Physician/N	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Records, P	w requires that been signed k should be deta	by	Part II. Other significant conditions contributing to d	eath but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
I Reco		Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	/	26. Place of Death		- Can (a) (b)
of	nding Phys ath. r: After this e funeral di	atlon: To	27. Manner of Death 28a. Date	Ínpatient 2 □ ER/Outpatier of Injury th, Day Year) 28b. Time of Injury	at 3 DOA 4 Nursing Hon	ne 5 Residence 8d. Describe how inju	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	4 Homicide build	e of Injury - At home, farm, str ing, etc. (Specify)		City or Town, Stat	
	the Hospin 24 houther the Funer	Medical	(Check only 2 Medical Examiner: On the boone) and man	asis of examination and/or in ner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	ed at the time, date an	nd place, and due to the cause(s)
)	To Toor	2	29b. Signature and title of certifier M.		29c. License number 0 5 9 3 9 8	FE	
_	10		30. Name and address of person who completed cau ALOK RUSTOGI, M	be of death (Item 23a) (Type,	V HOSPITAL,	ELKTON	, MARYLAND.
\$7	Sta Registr	- 1	31. Date filed (Month, Day, Year) 32. FEB 1 3 2006	degistrar's Signature			
DU	M1147 D-14/0	204	FEB 1 3 2006 Block	- 7			

Registrar DHMH 17 Rev 1/2001

FOLEY, MARY.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3 Time of Death 2 Date of Death edent's Name (First, Middle, Last) **Physician** 4c. County of Death 00120 /Medical 4b. City, Town, or Location of Death . Fecility Name (If not institution, give street and number) Examiner Hopkins Altmore of Year | If Under 2 7 OHIU 8. Date of Birth OCT. 26, 1988 5. Social Security Number n vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Min. 1 X M 2 □ F 17 Yrs 213 - 23 - 6046Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Frederick Frederick Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number States 21701 United 523 Logan St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes, 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status e filed within 72 hours after dail Hygiene.

other than "natural", or item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Student school 11 other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) mit. Pages 1 and 2 should be file pertment of Health and Mental Hypotrant: If Item 27 is marked oth y niury or other traumatic eventy Be Fox Deborah Burgess David Α. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 523 Logan St. / Frederick, Maryland David A. Fox / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem. Garden 02/10/2006 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit.
Deportrimportri 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, so heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Lause (Final disease or condition resulting in death) Desi Physician hours /Medical Due (o pr as a consequence of): Examiner hour Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ettending physicien and I for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day signed by the el 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to complet un of cause of death? 24a. Was an autopsy performed No 1 ☐ Yes 2) No 1 Tyes Attending Physician: ierel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Vinpatient Certification: To 2 ER/Outpatient 3 DOA this 27 Manner of Douth 28a. Dale of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the fi 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signalule and 29d. Date signed (Month, Day, Year) title of dertific 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, 32. Refistrar's Signature State Registrar

Frederick Memorial Hospital Frederick Fred	punty of Death rederick
Gloria Magdalene Fraley 4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital Funeral Director 5. Social Security Number 214-28-2440 Gloria Magdalene Fraley 4b. City, Town, or Location of Death Frederick Fre	y 2006 5:34 P M punty of Death rederick 9. Birthplace (State or Foreign County) Maryland 10d. Inside City Limits 1 Yes 2 No n of What Country? ed States Race - American Indian, Black, White, etc.
Funeral Director Usual Residence of Decedent 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Cod Frederick Frederi	9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No n of What Country? ed States Race - American Indian, Black, White, etc.
Funeral Director 5. Social Security Number 214-28-2440 1 M 2X F 74 1 M 2X F 74 1 M 2X F 74 1 Months Days Hours Min. (Month, Day, Year) Feb. 1, 1932 Usual Residence of Decedent	9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Tyes 2 No n of What Country? ed States Race - American Indian, Black, White, etc.
Usual Residence of Decedent	10d. Inside City Limits 1 □ Yes 2 M No n of What Country? ed States Race - American Indian, Black, White, etc.
Usual Residence of Decedent	10d. Inside City Limits 1 □ Yes 2 M No n of What Country? ed States Race - American Indian, Black, White, etc.
	n of What Country? ed States Race - American Indian, Black, White, etc.
Maryland Frederick Walkersville Maryland Frederick Walkersville 10e. Street and Number 10g. Citizer 10	n of What Country? ed States Race - American Indian, Black, White, etc.
10e. Street and Number 9950 Kelly Road 10f. Zip Code 21793 Unite 10f. Zip Code 21793 Unite 10f. Zip Code 21793 Unite 10f. Zip Code 21793 10f. Zip Code 21793 10f. Zip Code 21793 Unite 10f. Zip Code 21793 11g. Was Decedent Ever in U.S. Armed Forces? 11g. Was Decedent Ever in U.S. Armed Forces? 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	ed States Race - American Indian, Black, White, etc.
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	Black, White, etc.
1 Never Married 2 Married 1 Tyes 2 No Specify: Sp	
Widowed 4 X Divorced Vac or Dates	
3 Widowed 4 Divorced Year or Dates:	iouny. HILL CC
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working	of Business/Industry
The state of the s	-t C
TIVE Custodian 11. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Su	stment Company
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Su	mame)
Robert M. Harris Robert M. Harris Margaret Scally 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Time)	
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sum Margaret Scally 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town Michael Fraley / Son 9950 Kelly Road, Walkersville, MD 2	
20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Local	tion - City or Town, State
Marial 2 Cremation 3 Removal from State St. Paul's Cemetery 2/9/2006 Point	of Rocks, MD
Michael Fraley/ Son 9950 Kelly Road, Walkersville, MD 20a. Method of Disposition Date 20c. Local 20d. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral 1621 Opossum.town Tike, Frederick	
23a. Part1. Enter the response of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fluir List only one suse on each line. Immediate Cause-Final disease or condition resulting in death) Atherogal Least Candida Joscalo Disease Cause Final disease or condition resulting in death) Due to (or as a consequence of):	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): c. Due to (or as a consequence of):	
d. ————————————————————————————————————	
So the second of the past 12 months? So the past 12	d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	contribute to the cause of death?
Taltin. Stress significant continuous to continuous to continuous the underlying cause given in Part 1. 239. Did tobacco use 1 Yes 2 N 24a. Was an autopsy performed?	
The column and the co	24b. Were autopsy findings available
The second secon	prior to completion of cause of death?
The second of th	1 Yes 2 No
1 Yes 2 No	
Property of the control of the contr	
27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Yes 2 No	
27. Manner of Death Description of Death Description of Description of Death Description of De	Number or Rural Route Number,
2 Accident 3 Suicide 4 Homicide 4 Hom	d menn of as stated. ace, and due to the cause(s)
29b. Signature and utility of certifier 29c. License number 29d. Date s	signed (Month, Day, Year)
DO035152 2	.606
30. Name and 1 Idress of person who completed cause of death (Item 23a) (Type, Print) Thurmont, Mo	21788
State 31. Date filed (Mornt Clay, (bac) 2006 37 Seignard (pack)	Service /

			1 → For State Registrar	State of Ma	ryland / Dep	artment of H			giene 06	05519
	Physic		Decedent's Name (First, Middle, La		d Fit	tagena	1/2 Sv	2. Date of Dea Month 0 2	Day Ye	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give Manor Care 5. Social Security Number 6. S	e street and number)	ng Hoine	4b. City, Town, or	Location of Death SPV If Under 24 Hrs.	ing	4c. County of I	Jeath Lgomery
	Funeral Director		578-22-7748 Usual Residence of Decedent	M 2□F	81 Yrs.	Months Days	Hours Min.	August2	6,1924 W	Birthplace (State or Foreign Country) ashington, DC.
	e Maryland 8a-f show	ctor	10a. State 10b. County Maryland Montgome	ery	10c. City, Town or Lo Silve	Spring				10d. Inside City Limits 1 ☐ Yes 2 XNo
	3a or 24	i Dire	10e. Street and Number 12600 Galway Driv	re		10f. Zip Code 20904			10g. Citizen of Wha United	·
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itame 23a or 28a-1 show analy injury or other traumatic event, the Modical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:	0	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black, \	American Indian, White, etc. White
21215-0	within 72 ho	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5-	(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	ation furing most of work)	ring	16b. Kind of Busin	
Maryland 2	uld be filed Mental Hygie Irked other Itic evant, II	To Be Co	17. Father's Name (First, Middle, Last, David Edward Fitz		БОС	ok Binder	18. Mother's Nam Amy Mari		Maiden Sumame)	Lithograph Co.
Mary	nd 2 sho lith and P 27 is ma r trauma		19a. Informant's Name/Relationship (Ada B. Fitzgerald			ng Address <i>(Street a</i> Gracefiel				te, Zip Code) , Md. 20904
Baltimore,	Pages 1 au lent of Hea nut: If item		20a. Method of Disposition			osition (Name of matory or other place 1.1 Cemeter	8)	Date 006	20c. Location - Cit	y or Town, State Maryland
Balti	permit. Pag Department Important: any injury, once.		21. Signature of Funeral Service Licer	Supera	D20	Name and Address NaId V. E	s of Facility Borgwardt Mill Ko	Funeral	1 Home, P	A aryland 20705
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	.a		ter the mode of dying				Approximate Interval Between Onset and Death 2 Lay
0,	eate be executed was physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of a july that initiated svents resulting in death) Last	c	consequence of):					
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Division	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification:	3 Suicide 6 Could not be determined	building, etc.			V	City or Tow	vn, State)	or Rural Route Number,
	he Hosp n 24 hou he Fune bletely fii	edicai	29a. Certifier 1 Certifying Pt (Check only 2 Medical Examone)	ysician: To the best o niner: On the basis of and manner stat	examination and/or in	h occurred at the tim vestigation, in my op	ie, date and place, pinion, death occur	and due to the or red at the time, or	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
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29b. Signature and title of certifier 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) DR. JEROME S. PUTNAM, 5530 WISCONSIN AVE, SUITE 800, CHEVY CHASE, MD 20815	Ξ	or Att	rtiff	determined	28e. Place of Inj building, et	ury - At home, farm c. (Specify)	n, street, factory, office)			r Hurai Houle Number,		
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				31. Date filed (Month, Day, Year)						<u> </u>	-,,,		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiefje 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Feb. 16 2006 6:00 A Friedman Phyllis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Bowie 7205 Westwind Drive If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York 8. Date of Birth (Month, Day, Year) June 12,1927 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 □ M 2 🖾 F 78 Director 056-20-6366 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State or 28a-f show other traumatic event, the Medical Examiner must be nutified at 1 √Yes 2 No Director Bowie MD Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20715 *neturel', or Items 23a 7205 Westwind Drive Pages 1 and 2 should be filed within 72 hours after death 1 nent of Heatth and Mental Hygiene. nnt: If item 27 Is marked other than "neturel", or Items 23. Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 ☐ Yes 2X No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates: White þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Complet Elementary/Secondary (0-12) College (1-4or 5+) U.S. Govt. Secretary 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dora Grossman Charles Pincus 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bowie, MD. 7205 Westwind Drive 20715 Amy Lieberman / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If eny injury or Metropolitan Crematory 02/16/2006 Alexandria, VA. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. ou 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final xotroph Physician disease or condition resulting in death) /Medical ue to (or w a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Hesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 📉 No 10 this 28c. Injury at Work? funeral 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: Af
d in by the fur 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical yeleldmoo within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 6 106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4175 North Hanson Ct. Suite 203A Bowie, MD. Andrew S. Dobin, M.D. 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 4 2006 Registrar Colusi

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5522 Certificate of Death Reg. No. 3. Time of Death 2 Date of Deeth 1. Decedent's Name (First, Middle, Last) Year Day Month 09:30AM **Physician** 2006 IDNE KENE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner GROVE ADVENTIST tos PITAL MONTGOMER KOCKVILLE MDSHADY If Under 1 Year If Under 24 Hrs.'
Months Days Hours Min. 8. Date of Birth (Month, Dey, O2-12- Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthdey) 5. Social Security Number 6. Sex **Funeral** Hours 1□M 200 F MARYLAND WNE Director Usual Residence of Decedent parmit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantel Hygiene. Important: if Item 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other traumetic event, the Medical Evandres must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Bowie MONTGOMERY Funeral Director MARYLAMD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20720 6216 REE GIDEON 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Saltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) NFANT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JORDAN -AUCE T ENDELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GIDEON STREET, ATHER 6216 MD 20726 HAUCEITE WENDELL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State MORGANTOWN 03-13-2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses MEDICAL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Prematunto Lamine. Due to (or as a consequence of): Preterm Physician/Medical Examiner or Attending Physician: The law raquires that the death carificate be executed been signed by tha attanding physician and should ba datachad for usa as tha burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital to
within 24 hours after death.
To the Funerell Director: After this cartificata has been sign on the Funerell Director. After this cartificata has been sign on the funeral director, page 2 should the funeral director, page 2. 24a. Was an autopsy performed? Be Completed 21X No TUYES ZXNO 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Date of Injury (Month, Dey Year) 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2/12/06 61903 PMaller-30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Bethesda, MD 208+7. 10215 Fernwood Rd Suite 101 P, Maher-APGAR, MD Jucqueline

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month; Par

Year)3

2006

ORIGINAL

32. Registrar's Signature

			For State Registrar	State of Maryland		irtment of H			iene	05524	
	- F - 2	y	Decedent's Name (First, Middle, Last)					2. Date of Deat	h	3. Time of Death	
	Physici /Medic		Faye Anita Gra	ant				Februar	y 7,20	9:00A M	
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	Funeral Director		5. Social Security Number 6. Sex 1 1	7. Age (In yrs. Ia M 2X F 52	Yrs.	Months Days		Hrs. 8. Date of Birth (Month, Day, April 2]	Year) 953	Birthplace (State or Foreign Country) Virginia	
			Usual Residence of Decedent					1-1	,		
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	he Ma	Director	MD Prince G 10e. Street and Number	eorges Sui	tland	10f. Zip Code		1	0g. Citizen of Wha		
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	me 23	Funeral		2 Was Decedent Ever in U.S	i. 13. \	Vas Decedent of Hi	spanic Origin	? (Specify Yes or No-	14. Race -	American Indian,	
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9	eath certific attending p for use as f	/Me	IF FEMALE:	3c. If yes, outcome of pregnar	ncv				23d. Date of	at delivery	
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of Vital Records,	The law requate has been page 2 should	Completed						24a. Was a autops	med? dea	re autopsy findings available or to completion of cause of ath?	
ta	(G LT	0	25. Was case referred to medical				26. Place o	1 ☐ Yes of Death (Check only or		Yes 2□No	
Ţ	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 🔲 Inpatient 2 🛂	R/Outpatier	t 3 DOA Oth	00	ing Home 5 Resid		(Specify)	
	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl			ow injury occurred		
sio	Attending r death.	cati	2 Accident investigation 3 Suicide 6 Could not be	One Diese of Injury At he	form of		Yes 2 □ No		treat and Number	or Rural Route Number,	
Division	after death Director:	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, rarm, str)	еет, гастогу, опісе		City or Tow		or nutal notice (vulnice),	
	e Hospital or 24 hours afte e Funerel Dir letely filled in t	edical C		ician: To the best of my knowner: On the basis of examinat and manner stated.							
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and trie of certifier	\		29c. Licens			9d. Date signed (Month, Day, Year)	
	_		XXX	6		D00	4158	0	7-9	-00	
	531		30. Name and address of person who co	ND 7503 SI	irrat	Print) Rd C	linto	n, MD 20	135		
	Sta Registi		FEB 13 2005	32. Registra's Signat	ure						

06-1169 B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Unpend item#1,23a,27,28a-f,pen/ff,0853,3/8/06 IT

State of Maryland / Department of Health and Mental Hygiene () () ANDRAE GROSS 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) Andrei Gross 2. Date of Death 3. Time of Death Day Month Year Gross Andrei **Physician** 14, 2006 1420 FEB /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGES PRINCE GEORGES HOSPITAL CENTER CHEVERLY If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) Apr. 22, 1957 9. Birthplace (State or Foreign Country)
Wash., D.C. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 ☐ F 48 217-72-1585 Director Usual Residence of Decedent Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow Prince Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene.
and: If Items 22 is marked other then "naturel", or iteme 23a or 28a-f ehow and it for other treumatic event, the Medical Exampler must be notified as ury or other treumatic event, the Medical Exampler must be notified as Palmer Park 1 Yes 2 No Marylan¢ Director George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2004 Barlowe Place 20785 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) XYes 2 □ No IYes, Give 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Carpenter Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kenneth Gross Shirlev Sollers 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Gross/Father 2004 Barlowe Pl. Palmer Park, MD 20785 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Moses Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 3 Burial 2 Cremation 3 Removal from State 2/18/06 permit. Page Department of Important: If eny injury or once. Lothian, MD 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Sewell 1451 Dares Beach Rd. 21. Signature of Funeral Service Licenses Funeral Home Prince Fred., MD20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Narcotic intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \sum No certificate has 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 Proprient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 XYes 2 No this 28b. Time of InjuryFnd M After this funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: s after dea. 1 Natural 5 Pending 1:34 P 1 Yes 2 No investigation /14/2006 Fnd 2 Accident unk 6 X Could not be determined To the Hospital or Atte within 24 hours after de To the Funerel Directo completely filled in by the 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 5907 Dix St. N.E. Washington, D.C. 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide Found in car 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type Print) STREET, BALTIMORE, MARYLAND 21201 Greenberg 31. Date filed (Month, Day, Year) FEB

Jash

32. Registrat/s Signature 2006

NO

O.C.M.E

15, 2006

		1	For State Registrar		State o	of Marylar		artment of H		nd Me		giene Reg. No.	16	05526
			Decedent's Name (First, Midd	lle, Last)						2	Date of Dea	ath Day	Year	3. Time of Death
	Physici		Leona			Gilber	ct			F	ebruar			6:20 a M
	/Medio		a. Facility Name (If not institution	n, give str	eet and nu			4b. City, Town, or	r Location of	Death		4c. Cou	nty of Death	1
	LAMINI		7775 Swan L	ane				Owing	gs			Cal	vert	
No.	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.		If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8 Min.	. Date of Birt (Month, Da	h y, Year)	9. Birth Cou	nplace (State or Foreign untry)
	Director		526-65-6808	1 1 1	vi 2 ∑ F	92	Yrs.			7	April .	y Year) 30,191	3 Ari	zona
	p ,	} <u></u>	Usual Residence of Decedent 10a. State 10b. Count	v		10c. C	ity, Town or Lo	ocation						10d. Inside City Limits
	anyla •hov			, lvert	_		Owir							1 ☐ Yes 2 No
	N 94 9	ecto	10e. Street and Number	TACT			OWII	10f. Zip Code				10g. Citizen	of What Co	untry?
	with t	급						2073	6			τ.	J.S.A.	
	72 hours after death with the Maryland natural', or Items 23s or 28s-f show disel Exambles must be notitled at	Funeral Director	7775 Swan Lan		. Was Dec	cedent Ever in l	J.S. 13.	Was Decedent of H		in? (Spec	ify Yes or No		Race - Ame	ncan Indian,
	ltern Item	ů	 Marital Status Never Married 2 Ma 		Armed F	orces? 27 No			an, Mexican,	, Puerto Ri	can, etc.)		Black, White	e, etc.
36	rs aff	by F	3 Widowed 4 □ Divorce		If Yes, G Year or I	IVB		1 ☐ Yes 21 No	Specify:			Spe	ecity:	white
5-0036	2 hou	pel	15. Decede	nt's Educa	ation	,	16a. Dece	dent's Usual Occup	nation	of working	7	16b. Kind o	f Business/	Industry
The same of	n n n	ple	(Specify only high Elementary/Secondary (0-12)			(1-4or 5+)	life.	DO NOT use retire	d)	UI WOIKIIN				
2121	filed within Hyglene. other then "ent, the Mer	Completed	12				l l	nomemaker					own ho	me
	oths oth	Be	17. Father's Name (First, Middle									, Maiden Sun	_	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene if Health and Mental Hyglene item 27 le marked other then "natural", or flems 23a or 28a-f ehow then traumatic event, the Medical Examin ar must be notified at	2	Erastus Wil	lard	Mo	rtensen				arah	Elle		elson	
an	2 sho and h		19a. Informant's Name/Relation					ng Address (Street					wn, State, 2	Zip Code)
	1 and 2 Health 16m 27 other tra		Louise G. Hut	chins	son, c			Swan La	ne, Ov	vings Da	-		on City or	Town, State
a	permit. Pages 1 and Department of Healtmportant: If item 2 eny Injury or other 2005.		20a. Method of Disposition 1∑ Burial 2 ☐ Cremation	3 □Re	moval from	State	cemetery, cre	osition (Name of matory or other pla		Da	10			TOWN, State
Ĕ	Pages nent of I int: If its iry or o		4 Donation 5 Other		inovar non	Me Me	esa Cit	y Cemeter	<u>.</u> 0	2-11	-06	Mesa	, AZ.	
a =	Departition of the point of the	1	21. argument of Funeral Service	e Lic-rise	9			2. Name and Addre		-				00726
m	\$ 2 E 2 2		Lyn	11	eale			kausch Fu					ngs, M	
100			23a. Part1. Enter the disease, shock, or heart (ailyre. Li	or complic	ations that	caused the dea	ath. Do not er	iter the mode of dyi	ng, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition			Lun	noho	na						Lane
	/Medical		resulting in death)	(a.	Due to	o (or as a conse	equence of):	7 0						0
The same	Examiner		Conventially list conditions	b.										
	ener de venere	ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	"	Due to	o (or as a conse	equence of):							
	cuted nd ransl	Examin	that initiated events	c.										
Ó	ate be executed obysicien and the burial-transit	EX	resulting in death) Last		Due to	o (or as a conse	equence of):							
8760,	ate br	dlcal		d.										
Ö	leath certificate attending phys I for use as the	0	IF FEMALE:										22.77	
Box	th ce tendi	Physician/M	23b. Was decedent pregnant in the past 12 months?	23	1 🗀 Live	utcome of preg birth 2 Fe	tal death 3	Ectopic pregnanc	су			23d	. Date of de Month	livery Day Year
	0 0 0	SICI	1 □ Yes 25 No		4∐Pre	gnant at time of known	death 5	Other (specify) _						
P.0	by ac	h	9 ☐ Unknown			1t b. 1 = -1 =	tal	da.eb.ia.a. aa.uaa a.	ron in Dart I		23e Did	tobacco use	contribute t	o the cause of death?
	es tha igned be det	<u>م</u>	Part II. Other significant cond	Itions con	tributing to	death but not re	esulting in the	underlying cause gi	IVOIT III F &ILL	•		Yes 2	7	robably 4 Unknown
of Vital Records,	v requir been si should	Completed									1			
e C	as be	ple									24a. Wa	psy	24b. Were a prior to death?	utopsy findings available completion of cause of
<u>m</u>	The lav	Con									1 Yes	279 No	1 Ye	s 2 No
ita	ician: Th certificate rector, pag	Be (25. Was case referred to medi examiner?							e of Death	(Check only	ohe)		
>	hysic nis ce I dire	To T	1 ☐ Yes 2 No	Н			☐ ER/Outpati	ent 3 DOA		ursing Hon	/-	idence 6		ecify)
0	Jing Ph J. After th funeral		27. Manner of Death SNatural 5 ☐ Pen	dina	28a. Dat (Mo	te of Injury onth, Day Year)	28b. Time Injury	W			8d. Describe	how injury o	ccurred	
Division	Attending Physician: r death. ector: After this certific by the funeral director.	Certification:	2 ☐ Accident inve	stigation Id not be					Yes 2		Of Leastion	(Street and A	lumbar ar F	Rural Route Number,
ž	or Att	T L		mined	28e. Pla bui	ce of Injury · At Iding, etc. (Spe	thome, larm, : ecify)	street, lactory, office	9	2	City or To	own, State)	vuiliber or r	dial nodio wantoo.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu										and due to the		nd manner a	e stated
	Hospital	edical	(Check only 2 Medic	ying Phys al Examir	ner: On the	basis of exami	(nowledge, de ination and/or	ath occurred at the investigation, in my	opinion, dea	ath occurr	ed at the time	e, date and pl	ace, and du	e to the cause(s)
	within 2 To the complet	Med	one)	dior ()	and ma	anner stated.		29c. Licer	nse number			29d. Date s	signed (Mor	nth, Day, Year)
	To To		29b. Signature and title of cen	Sel	12/1	of)	1.7	1	n / -	- /		Delmi	and	6 m, 2006
			- Comme	U	~	V 1	MU	DO	1591	061		70070	1	-)0-00
	i.		30. Name and address of pers	on who co	mpleted ca	ause of death (I	tem 23a) (Typ	e, Print) Road,	Gil	د ه	12 4	more	Fred	enik MD
	ь		ARATI PATI	21 1	7 / 20	U HOSP	nnature	road)	3011	<u>a</u>	X V	-,		QUOTE
	S [.] Regis	trar	31. Date filed (Month, Day, Ye	5	32	. Registrar's Sig	bull							
	110913	or en	1 L L D () 7 0 0 0	A Starte	and the	100	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05527 State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 21, 2006 11:30a January Harry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Avalon Manor Nursing Center Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days 1 M 2□F 26, 1933 Pennsylvania 233-52-1657 72 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a. State or 288-f ehow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No WV Director Berkeley Martinsburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 200 E. Stevens Street #507 25401 U.S.A. "naturel", or Itams 23a by Funeral death 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Affined Polices? 1∑Yes 2 □ No If Yes, Give Year or Dates: 1956-58 Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Agency al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) National Security 12 translator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be f Health and Mental Elizabeth Goff Ethal James Perry 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 13, Tracy's Landing, MD Daniel Goff, son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of H
Importent: If ite
eny injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 01-26-06 Alexandria, VA yre of Funeral Service Lice see 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,_ 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition Pnysician monde resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live/birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Tursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of 27. Manner of Death Certification: After Hospitel or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determine 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

21215-0036

Baltimore, Maryland

Box 68760

P.O.

Records,

Division of Vital

State

Registrar

30. Name and address of person who completed cause of geath (Item-23a) (Type, Print)

4

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 0 0 Physic /Med Exam

1 - For State Registrar	State of Maryland	Cert	ificate of L	Death		Reg. No.	00040				
Registrar 1. Decedent's Name (First, Middle, L	ast)	0071	modito of I		2. Date of Dea	ıth	3. Time of Death				
Joanna	Mae Gant	t			Month O2/	Day Year 10/ 2006	12:21a ^h				
4a. Facility Name (If not institution, g	ve street and number)		4b. City, Town, or	Location of		4c. County of Death					
Civista Medica			La I	lata		Char1	es				
	Sex 7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Birt (Month, Pa) APTIL	9. Birth 15,1926 Ma	place (State or Foreigntry) ryland				
Usual Residence of Decedent	10-01-3		-41				10d. Inside City Limit				
	0a. State 10b. County 10c. City, Town or Location										
	ary's	Mechai	nicsvill	e		10g. Citizen of What Co	1 ☐ Yes 2 🐴				
10e. Street and Number 26931 Tin Top S	chool Road		_	0659		USA	arta y :				
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	ispanic Origi n. Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Amer Black, White							
1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced			Yes 2 No		,		hite				
15. Decedent's (Specify only highest of	16b. Kind of Business/	industry									
Elementary/Secondary (0-12)	College (1-4or 5+)	1	Homemake	r		Own Hom	ie				
17. Father's Name (First, Middle, La	st)			18. Mother	s Name (First, Middle,						
Guy Mag	his			Evε	elyn I	Lehman					
19a. Informant's Name/Relationship Kenneth E. Gant	(Type, Print)	19b. Mailing 2693	Address (Street 1 Tin To	and Number p Scho	or Rural Route Number	er, City or Town, State, 2 echanicsvile	ip Code) , MD 2065				
20a. Method of Disposition	20b. Pla	ce of Dispos	ition (Name of	.	Date	20c. Location - City or	Town, State				
1 ☑ Burial 2 ☐ Cremation 3	□Removal from State Trii	netery, crem n i t v M	atory or other plac 1emoria 1	Garl 1	2/14/2006	Waldorf, Ma 128, Charlo	aryland				
21. Signature of Funeral Service Lie	ensee St.	22. Br	Name and Addre	ss of Facility -Echo	ls Funeral	Home, P.A.	2062				
shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Mu LTI - Due to (or as a conseque	PSES	AN F				Interval Batween Onset and Death				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23d. Date of de Month	23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE LUNG DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy findings available prior to completion of cause of											
HYPOTHY	ROIDISM				1 ☐ Yes	ormed? death? 2 No 1 ☐ Yes	3				
25. Was case referred to medical examiner?	Hamitai, A.		0+		of Death (Check only						
1 ☐ Yes 2 2 No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending		R/Outpatien 28b. Time of Injury	28c. Inju	ry at rk?	28d. Describe	idence 6 Other (Spe how injury occurred	ecify)				
2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be One Blace of Injury . At hor	me, farm, stre]Yes 2∏1	28f. Location	n (Street and Number or Rural Route Number, Town, State)					
29a. Certifier 1X Certifying (Check only one)	Physician: To the best of my know xaminer: On the basis of examination and manner stated.	vledge, death on and/or inv	n occurred at the t vestigation, in my	ime, date an opinion, dea	d place, and due to the th occurred at the time	a cause(s) and manner a , date and place, and du	s stated. e to the cause(s)				
29b. Signature and title of certifier	10		29c. Licen	se number		29d. Date signed (Mon					
250. Signature and title of Stillier	a garde		į	- 260)61	2-10-	2006				

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be defached for use as the burlar-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vidyasagar Anmangandla, MD 10583 Theodore Green Bldv. White Plains, MD 20695
31. Date filed (Month, Day, Year) 32. Registrate Signature

D - 26064

State Registrar

FEB 1 6 2006

Funera Director

"natural", or itema 23a or 28a-1 show salcul Examinat must be notified at

Priysiciai /Medica Examine

 $\int_{C} C d \ln d = \frac{C d \ln T}{C \ln T}$ Baltimore, Maryland 21215-0036

			_ FOF	partment of Health and Mental Hyertificate of Death	rgiene Reg. No. 006 05529
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of De Month	aath Day 8, 2006 3. Time of Death 6:35 P M
100	/Medic	al	Margaret Etoile Gulli 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Examin	let	St. Mary's Nursing Center	Leonardtown	St. Mary's
*	Funeral Director		5. Social Security Number 5. Social Security Number 6. Sex 1 M 2 T F 92 Yrs.	// If Under 1 Year If Under 24 Hrs. 8. Date of Bir Months Days Hours Min. (Month, Days Hours Min. February	nth 9. Birthplace (State or Foreign Country)
	pu *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I		10d. Inside City Limits
	f eho	tor		1ywood	1 ☐ Yes 2 ☐ No
	r 28a	Irec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	15 with	alD	24775 Barbara Lane	20636	USA
92	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Ie marked other than "naturel", or Itema 23e or 28e-f e-how apprintly or other traumatic event, I'm Medical Exactional Item Indilliad all and DECE.	by Funeral Director	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes Give X	. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 25(No Specify:	o- 14. Race - American Indian, Black, White, etc. Specify: White
Ö	hours ture!	ed b	3 √ Widowed 4 □ Divorced Year of Dates: 15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Kind of Business/Industry
Maryland 21215-0036	within 72 ane. than "ne	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0·12) College (1·4or 5+)	e kind of work done during most of working DO NOT use retired) phone Operator	Telephone Company
d 2	Hyginer other	Be Cc	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	
/lar	uld be Menta arked stic ev	To B	Walter Dawkins Clements	Sarah Louise Va	llandingham
/an	2 sho			ling Address (Street and Number or Rural Route Numb	
	1 and Health em 27 ather t		20a Method of Disposition 20b. Place of Disp	Barbara Lane, Hollywood, Maryl	20c. Location - City or Town, State
TOL	Pages ent of nt: If it		1XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cr	February Lus Cemetery 14, 2006	Leonardtown, Maryland
Baltimore,	Departm Departm Importar eny Injui		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Mattinelev-Gardiner Funeral Home	e. P.A.
	4		23a. Part 1. Enter the disease, or complications that caused he death. Do not e		arrest, Approximate Interval Between
19 1 18 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Gayus dially lict conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	whe Candension	Can desease Onset and Death
x 68760,	eath certificate be executed attending physician and for use as the burial-transit	dlcai	Due to (or as a consequence of): d		
.O. Box	that the death c ed by the attend detached for us	Physician/Me		□ Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
rds, P	w requires that been signed to should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	and the state of t	tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
Vital Record	The law ate has b page 2 sl	Completed		24a. Wa auto perf 1 ∐ Yes	
Vita	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death Check only	
	Phys this ral di	1:10	1 Inpatient 2 EH/Outpati		idence 6 Other (Specify) how injury occurred
Division of	or Attending after death. Director: After in by the fune.	Certification:	1 X Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	Work? M 1 Yes 2 No street, factory, office 28f. Location	(Street and Number or Rural Route Number,
á	Hospital or Attan 24 hours after deat Funeral Director: stely filled in by the		4 Hornicus Building, etc. (Specity)		own, State)
	Hos 24 h Fur stely	Medical	(Check only one) Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the time	, date and place, and due to the cause(s)
	To the within To the comple	-	29b. Signature and title of certifier	29c. License number /)) Y Z & 5	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Typi	,	- 100
			William D. Boyd, II, M.D. 25365 Point Look	out Road, Leonardtown, Maryland	20650
	Sta Registi		31. Date filed (Month, Day, Year) See 32. Register's Signature FEB 1 0 2006	Beerle .	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath Day Yaar Month Thelma Catherine Green February 5,2006 5:00 P. 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Prince George's Hvattsville Sacred Heart Home, Inc. If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) If Undar 1 Yaar Birthpleca (State or Foreign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Days Months Hours 1 □ M 2 1 F 97 Yrs 576-28-6765 3/15/08 Wash.D.C. Usual Residence of Decedent 10d. Insida City Limits 10a. Stata 10b. County 10c. City, Town or Location 1 ☐ Yas 2 No D.C. Washington 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 2436 Otis St., N.E. U.S.A. 14. Race - Amarican Indian, Black, Whita, etc. 20018 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forcas? 11. Marital Status 1 ☐ Yas 2 No 1 ☐ Navar Married 2 ☐ Married Specify: Black 1 ☐ Yas 2 € No Specify: f Yas, Giva Yaar or Datas: 3 Widowad 4 □ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) 12th Collega (1-4or 5+) Shipper/Mail Dept. U.S. Government 18. Mother's Nama (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middle, Last) John Henry Francis Mary J. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4900 Keir Court, Suitland, Maryland 20746 John H. Francis/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cem. 2/14/06 Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility H.S. Washington & Sons Co., Inc. W. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Effar the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in death) Congestive Heart Failure Due to (or as a consequance of): Hypertensive Cardiovascular Disease Sequantially list conditions, if any, leading to immadiate causa. Enter Undarlying Ceuse (Disease or injury that initiated avants resulting in death) Last Due to (or as a consequence of): Dua to (or as a consaquanca of) 23b. Did tobacco usa contributa to the causa of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yas 2 No 3 Probably 4 Unknown Progressive Cognitive Decline 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 1No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetiant 3 ☐ DOA Other: 42 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yes 2€No 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 5 Pending Injun

or Attending Physician: The law requires that the death certificate be axecuted as the bunal-transit P.O. Box 68760, Division of Vital Records, death. after death

Physician

Examiner

/Medical

Physician

Examiner

Funeral

Director

ns 23a or 28a-f shortman be notified at

Director

Funeral

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Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumetic event, the Medical Examiner must be notified at

Saltimore, Maryland 21215-0020

/Medical

Physician/Medical Examiner Be Completed by Certification: To

Medical

2 Accident

3 ☐ Suicide

4 Homicida

To the Hospital o within 24 hours af To the Funersi Di complataly State

filled in by

1 Certifying Physician: To tha best of my knowladge, death occurred at tha tima, date end plece, end due to the cause(s) and manner as steted. 2 Medical Examinar: On the besis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

investigation

6 Could not be datarmined

28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

29c. License number D0051122

1 TYas

2 No

29d. Date signed (Month, Day, Year) February 6,2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

Esmerando O. Juanitez, M.D. 1160 Varrum St., N.E., Washington, D.C. 20017 31. Data filed (Month, Day, Year)

FFR 0 9 2006

. Registrar's Signature

DHMH 16 Rev 6/95

Hegistrar

			1 - For State of Marylar Registrar	nd / Departm			•	05531
	Dhuoisi	an	1. Decedent's Name (First, Middle, Last)			2. Date of De Month		3. Time of Death
	Physici /Medio		Sandra Louise GRIEMSMANN			Februare	1 10 200%	0013 M
	Examir	ier'	4a. Facility Name (If not institution, give street and number)	4b. 0	City, Town, or Location		4c. County of Death	
	Funeral	1	Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs.		Hagerstow nder 1 Year If Under	r 24 Hrs. 8. Date of Bir	Washingt th 9. Birth	pplace (State or Foreign untry)
D.	Director		271-34-3117 1□M 2∏F 69	Yrs. Mont	ths Days Hours	Min. (Month, Da		Ohio
	pu .		Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ity, Town or Location				10d. Inside City Limits
	faryla hov	ō						1 ☐ Yes 2√2 No
	286-1	Director	Maryland Washington 10e. Street and Number	Hagersto	Wn Zip Code		10g. Citizen of What Cou	
	d within 72 hours after death with the Maryland Jene. Ir than "natural", or itame 23a or 28e-f ahow Ita Medical Evarta at must be cutified at		10909 Larch Avenue		21740		USA	•
	death	Funeral	11. Marital Status 12. Was Decedent Ever in L Armed Forces?	J.S. 13. Was D		rigin? (Specify Yes or No In, Puerto Rican, etc.)		
9	or its	교	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No		s 2 No Specify		Black, White	e, etc.
21215-0036	ural',	d by	3 Wildowed 4 Divorced Year or Dates:					White
15-	in 72 in at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's l (Give kind or life. DO NO	Jsual Occupation f work done during mo: T use retired)	st of working	16b. Kind of Business/I	ndustry
212	within liene. r than "	mo du	Elementary/Secondary (0-12) College (1-4or 5+)		maker		Her own 1	nome
פ	e filed Il Hygie other vant, II	a	17. Father's Name (First, Middle, Last)	110410		er's Name (First, Middle		70110
/lai	should be ind Mental marked o	ToB	Ernest Novis		Eve	lyn Swigert		
Maryland	0 0 0	1	19a. Informant's Name/Relationship (Type, Print)Husband	19b. Mailing Add	ress (Street and Numb	per or Rural Route Numb	er, City or Town, State, Z	ip Code)
	s 1 and f Health itam 27 other tr		William K. Griemsmann Sr. 20a. Method of Disposition 20b.	10909 L Place of Disposition	arch Avenu	e, Hagerston	wn, Maryland	1 21740
Baltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crematory	or other place)		20c. Location - City of	IOWII, State
Ē	permit. Page Department Important: If any injury or		4 Donation 5 Other (Specify) Ce 21. Signature of Funeral Service Licensee		fem. Park e and Address of Facil		Hagerstown, ch Funeral H	
Ba	Depa Impo		Decit Home				rstown, Mary	
			23a. Part1. Enter the disease, or complications that caused the dea					Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	. 11		2.1	10	Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death) August 1 August 1 Due to (or as a consection of the conditions) Sequentially list conditions,	quence of):	caprice	spinarory	pour	
	Examiner		Sequentially list conditions b. Chronic o	5 much	ue pulm	onen di	22 a92'	
	pe sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
_	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consec	quence of):				
760,	ate be executed hysician and the burial-transit	calE		, , .				
687	ificate g phys as the		0.					
Вох	death certifica e attending ph id for use as th	N/U	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fett				23d. Date of deli	very
	death	sicia	1 ☐ Yes 2 ☐ 100 4 ☐ Pregnant at time of c		ic pregnancy (specify)	<u> </u>	Month	Day Year
P.0	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/Med	9 Unknown					
	signed I	Ď	Part II. Other significant conditions contributing to death but not res	sulting in the underlyi	ng cause given in Part		obacco use contribute to	the cause of death?
Records,	w requir been si shoutd t	Completed	Hypertention					
Rec	Φ £ 0	ldm				24a. Was		topsy findings available completion of cause of
e	icien: Th certificate ector, pag	e Co	25. Was case referred to medical			1 ☐ Yes	2 2 √ √0 1 ☐ Yes	2 No
of Vital	Phyelcien: this certific ral director,	To B	examiner?	ER/Outpatient 3	Other	e of Death (Check only o	dence 6 □Other (Spec	note)
10	iding Phye th. After this funeral di		27. Manner of Death 28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?		how injury occurred	,
ior	Attanding in death. actor: Atterby the funer	atlo	2 Accident investigation	M	1 Yes 2]No		
Division	or Attan after deat Diractor: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - Athbuilding, etc. (Speci	nome, farm, street, fac ify)	ctory, office	28f. Location (City or To	Street and Number or Ru wn, State)	ral Route Number,
	ospital or hours afte uneral Dir	S						
	I 4 IT 0	edlcal	29a. Certifier (Check only one) (Check only one) (One) (Check only one)	owledge, death occur ation and/or investiga	red at the time, date a tion, in my opinion, de	nd place, and due to the ath occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month	n, Day, Year)
	->-0		I has wa.	no	D625	88	2/10/	06
			30. Name and address of person who completed cause of death (Ite	m 23a) (Type, Print)			•	
Ó	4-4		JUDAH MBAOUA, 251 E.	ANTIET	Am ST, 1	HAGERIST	DWN, r	20 21740
	Sta Registr	-	31. Date filed (Month, Day, Year) FEB 1 3 2006 32. Registrar's Sign	D. Spars	w		(10 2174C

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 14:25 February 7,2006 Alice LaRue Garrett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Snow Hill Worcester Snow Hill Nursing & Rehabilitation Ctr. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days, Hours Min. October 9,1922 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number Funeral 1 M 2 F Maryland 83 Director 213-16-0809 Usual Residence of Decedent Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Martal Hyghens and the Health and Martal Hyghens is neturel; or Items 23a or 28e-1 show and it items 7 is marked other then "neturel; or Items 23a or 28e-1 show any or other treumetic event, It is Marical Examinat must be notified at uny or other treumetic event, It is Marical Examinat must be notified at 1 X Yes 2 ☐ No Director Snow Hill Maryland Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21863 Funeral 430 West Market Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Be Completed by 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry . 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Housewife 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mettie Basler Beyer William Beyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 36225 Purnell Crossing Rd. Willards, Maryland 21874 Natalie Wien/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Spring Hill Memory permit. Page Department of Importent: If eny injury or once. 2/11/06 Hebron, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gardens 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Holloway Funearl Home P.A. 501 Snow Hill Rd. Salisbury, Maryland 21804 23a. an / Enier the disease, or complications that caused shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Donc /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Ś 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide determined 4 Homicide within 24 hours a To the Funerel [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title 9 certifier eb. 07. 2006 person who completed cause of death (Item 232) (Type, Print) St. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar FEB I 0 2006

			For State Registrar	State of Ma	ıryland		artment of the control of the contro			- '	giene	16	05533	
	Physicia	58	Decedent's Name (First, Middle, La	ist)						2. Date of Dea	ath Day	Year	3. Time of Death	
	Physicia /Medic	al.	PAMELA 4a. Facility Name (If not institution, given		RAY		4b. City, Town,	or Location		JANUARY	12, 2006		2:47 A M	
	Examin	er	THE JOHNS HOPKINS				,,	BALTI			40. Oddin	ty of Death		
	Funeral Director		5. Social Security Number 6. 9		(In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under		8. Date of Birt (Month, Da 8/5/19	th y, Year) 952	9. Birth Cou	place (State or Foreign intry) WV	
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits	
	Ba-fah	Director	WV BERKEL	EY	H	IEDGES	_						1 ☐ Yes 2 🂢 No	
	with the	Dire	10e. Street and Number	DΤ			10f. Zîp Code	05407			10g. Citizen o	of What Cou JSA	untry?	
	death	Funeral	25 PRESTON COU	12. Was Decedent E Armed Forces?	ver in U.S	6. 13.	Was Decedent of If Yes, specify Cul	25427 Hispanic Or	rigin? (Spec	cify Yes or No		14. Race - American Indian, Black, White, etc.		
20	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f ahow int, the Medical Eraminer must be notified a	by Fu	1 Never Married Married 3 Widowed 4 Divorced	1 Yes 2 N If Yes, Give A Year or Dates:	o	1	1 ☐ Yes 2 ☐ XNo			iouri, Otor,	Spec	rify:		
-00030	2 hour		15. Decedent's E	ducation		16a. Dece	dent's Usual Occu	pation	-4 -4	_	16b. Kind of		HITE ndustry	
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N D	be filed within 72 hours after death with the Marylar at all Hygiene. and Hygiene. ad other than "natural", or liems 23a or 28a-1 ahow other than "natural", or liems 73a or 28a-1 ahow ovent, the Medical Examiner must be notified at	a)	12 17. Father's Name (First, Middle, Las.				MOTILIN 3		er's Name	(First, Middle,	Maiden Sum		111011	
/land	should be nd Mental i marked o umatic eve	To B	WILLIAM PRESTO	N WOOD					N	ELLIE E	BUTTS		590	
Man	2 10 20 10		19a. Informant's Name/Relationship				ng Address <i>(Stree</i> PRESTON				-			
ย์	s 1 and f Health item 27 other tr		FLOYD NELSON GRAY, 20a. Method of Disposition		20b. Pla	ace of Dispo	esition (Name of matory or other pl	1	JANUAR		20c. Location			
Ē	mit. Pages 1 an rtment of Heal ortant: If item 2 r njury or other 3.		1 XX Surial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Special Control of		1		CEMETERY		16, 20			HEDGES	VILLE, WV	
	permit. Depart Import ary nj		21. Signature of Funeral Service Lice	nsee		B	ROWN FUNER	AL HOM	WARTINS	BOX 82	1, 327 W V 25402	. KING	ST.,	
	0210		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each lin	the death	. Do not ent	er the mode of dy						Approximate Interval Between	
ı	Physician		Immediate Cause (Final disease or condition resulting in death)	aSEPSIS									Onset and Death 1 MONTH	
	/Medical- Examiner			Due to (or as:		ence of):							2 MONTHS	
	P ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unique	Due to (or as a	consequ	,							Z HORTHS	
_	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. HEPA									25 YEARS	
2/00	e y e	ical		d										
ž X	certificate Iding phys	/Med	IF FEMALE:	23c. If yes, outcome	of pregnar	ncy		V-5-	-		234 [Date of deliv	Venu	
.C. Box	atter for u	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ XNo 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3[Ectopic pregnant Other (specify)	cy				Month	Day Year	
λ. T	w requires that the de been signed by the s should be detached	by Pr	Part II. Other significant conditions	contributing to death bu	ıt not resu	lting in the u	nderlying cause g	iven in Part	I.				the cause of death?	
cords	requir				,					10		-	obably 4 Unknown	
Ŭ	The lay ate has page 2	Completed								24a. Was autor perfo 1 Yes		prior to c death?	topsy findings available completion of cause of	
VII		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ ☒o	Hospital:	nt 2∏E	ER/Outpatier	nt 3 DOA	th a m		(Check only only only only only only only only	one) dence 6 □C	ther (Spec	eifv)	
ion oi	nding Phys tth. :: After this e funeral di	tion: T	27. Manner of Death 1 X Xatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	v	28b. Time o Injury	f 28c. Inj		2		how injury occ		,,	
DIVISION	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	3 Suicide 6 Could not lead to determined		iry - At hor . (Specify)	me, farm, sti	reet, factory, office)	2	8f. Location (3 City or Tox		nber or Ru	ral Route Number,	
	e Hospit 24 hours e Funera letely fille	edical (29a. Certifier 1 X Certifying P (Check only one) 2 ☐ Medical Exa	hysicien: To the best of miner: On the basis of and manner sta	examinati	vledge, deat ion and/or in	h occurred at the vestigation, in my	time, date a opinion, de	nd place, a	nd due to the d at the time,	cause(s) and date and place	manner as e, and due	stated. to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of pertifier					nse number			29d. Date sign			
				M.D.	nath (It	0201/7		8-000			2/11	12	006	
1.	le		ERIC J. HANLY,		E ST	REET,		RE, MO	2128	37				
: ;	Sta Registr		31. Date filed (Month, Day, Year).				me							

			For State Registrar	State of Maryland /	•	artment of F		and Me		iene	5 05534
	Physici	an	1. Decedent's Name (First, Middle, Las	Oliver Goodyear	<u></u>			2	Month	Day	Year OS, ON A M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of	of Death	007000	4c. County o	
			110 Kirk Road	7.4	to trade along a	E1kton		24 Hrs I r	3. Date of Birth	Ceci	
	Funeral Director		221-20-8296	7. Age (In yrs. last M 2□F 68	Yrs.	Months Days		Min.	May 12,	1937	9. Birthplace (State or Foreign Country) Delaware
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	ocation					10d. Inside City Limits
	a-f sh	ctor	Maryland Cecil	E1kt	ton						1 ☐ Yes 2 📉 No
	with the	Director	10e. Street and Number			10f. Zip Code			1	Og. Citizen of W	
	eath v	era	110 Kirk Road	12. Was Decedent Ever in U.S.	13.	21921 Was Decedent of		gin? (Spec	ifv Yes or No-		States - American Indian,
36	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. markad other than "natural", or liems 23a or 28a-f show imatic event, the Madical Examinar must be molitied at	by Funeral	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1954-1) Types 2 \(\subseteq \) No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣 No			ican, etc.)	Specify:	white, etc. White
21215-0036	72 hou nature	eted	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occu	during mos	t of working	9	16b. Kind of Bus	siness/Industry
121	within no.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	<i>DO NDT use retire</i> neral Cor	ed)			Constr	ruction
d 2	filed v Hygie other t		9 17. Father's Name (First, Middle, Last)		Gei	nerar con			(First, Middle,	Maiden Sumame	
/lan	should be ind Mental s marked umatic ev	To Be	Zebulon Goodyea	r			Rut	h Hen	derson		
Maryland			19a. Informant's Name/Relationship (7) Christine M. Go			ng Address <i>(Stree</i> Kirk Road					
	Pages 1 and 2 ment of Health a lant: If Item 27 is lury or other trau		20a. Method of Disposition	20h Place	of Dieno	nsition (Name of		Febru			City or Town, State
Baltimore,	Page ment clant: If		1 X Burial 2 Cremation 3 C 1 Donation 5 Other (Specify	Ivemo	riai	matory or other pla Veterans Cemetery	3	23, 2	.006		Delaware
Ball	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licen	Carly	10		ockton	Stre	et, El	kton, Ma	aryland 21921
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death. It one cause on each line.	Do not en	ter the mode of dy	ing, such as	cardiac or	respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ASCVD Due to (or as a consequen	ce of):						18-215
	Examiner		Sequentially list conditions,	b							
	ed ed	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ce of):						
v o	ate be executed hysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a consequen	ce of):						
8760,	cate be physici	dical		d	-						
O. Box 6	Physiclan: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rall director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3[□Ectopic pregnant □ Other (specify) _	эу			23d. Date of delivery Month Day Year	
ds, P.O.	uires that the signed by Id be detacted	b	Part II. Other significant conditions of	ontributing to death but not resulting	ng in the u	underlying cause g	iven in Part	I.	23e. Did to	obacco use contribute to the cause of death? Yes 2 \[\sum No 3 \] Probably 4 \[\sum Unknown \]	
Records,	ne law requir s has been si ge 2 should	Completed							24a. Was a autop perfor	sy p	Vere autopsy findings available rior to completion of cause of leath? □ Yes 2□ No
Vital	ysiclan: The is certificate hadirector, page	a)	25. Was case referred to medical				26. Piac	e of Death	1 ☐ Yes (Check only o		Lifes 2LiNo
of Vi	Physicl this cer al direc	To B	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatie					lence 6 Othe	
o uc	ling After fune		27. Manner of Death 1 X Natural 5 ☐ Pending	(Month, Day Year)	lnjury	We	ury at ork? □Yes 2□		8d. Describe h	ow injury occurr	ed
Division	ospital or Attending hours after death. uneral Director: After y filled in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		e, farm, st				8f. Location (S City or Tow		er or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Ce	(Check only 2 Medical Exer	ysician: To the best of my knowle	edge, dea	th occurred at the	time, date a	nd place, a ath occurre	nd due to the o	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
	vithin 2 o the	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licer	nse number			29d. Date signed	1 (Month, Day, Year)
	e- > F- 0		> If Jacks,	MD		015	314	-		Februar	y 20, 2006
	241		30. Name and address of person who	Union therita	IF	1k Ton	177				
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 4 2006	32. Registrar's Signature	Jose	W	.,				
		38			£						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month. Physician IAN 2000 5010 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death ne (If not institution, give st et and number) Examiner HEVE TEOR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1₽M 2□ F Yrs. Director Usuel Residence of Decedent deeth with the Marylend 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Madical Examinar must be notified at 1 Yes 2 No Directo 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 14. Race - Amarican Indian, Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be flied within 72 hours efter to Department of Haaith and Mentai Hygiane. Introcrant: If teem 27 is marked other than "natural", or fler any Injury or other traumatic event 1 ☐ Yes 2 ☑ Ho If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 121-NO Specify: Baltimore, Maryland 21215-0020 ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) during most of working Elementery/Secondary (0-12) College (1-4or 5+) IONE None 17. Father's Rame (First, Middle, Last) Be 2 19b. Majling Address (Street and Number or Rural Route Number, 19a. In rmant's Name/Relationship (Type, Print) 700 20b. Place of Disposition (Name of cemetery, crematory or other place)

P.G.1+. C Date 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-9-200 CHEVERLY, MD 1 Burial 2 Uremauon Sun Release to Hospital 22. Nama and Address of Facility 21. Signature of Funeral Service Licensee HOSPITAL DRIVE, CHEVERLY, MD 3001 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) Liner Due to (or as a consequence of) Physician/Medical Examiner ate hes been signed by the attanding physicien and page 2 should be detached for use es the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Chonoamusmiss Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco usa contributa to tha cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 22No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 8 Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) á 4 ☐ Homicide Hospital within 24 hours to To the Funerei I 1. Confiring Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as steted.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) To the

State Registrar 29b. Signature and title of certifler

30. Name and eddress of person

31. Date filed (Month, Day Year)

tho completed cause of death (ftem 23a) (Type, Print)

32 Registrar's Signature

2006

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00026819

29d. Date signed (Month, Dey, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 11em 31 per dvr 852 2-27-06 vt. State of Maryland / Bepartment of Health and Mental Hygiene 1 6 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day 500PM Physician debrand tebruary 10 2006 /Medical 4. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore But work
If Under 1 Year If Under 24 Hrs. Maryland Medical Center University 0 8. Date of Birth (Month, Day, Year) 10-30-1963 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex J Months Days Hours Min 1 ■ M 2 □ F 42 052-64-4363 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No Directo Mechanics ville MD St. Mary's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20659 39124 Jocelyn Way Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married ■Yes 2 No 1 Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Navy 12 Non-commissioned Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Nickla G. Hildebrand Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39124 Jocelyn Way, Mechanicsville, MD 20659 Tamara Hildebrand/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Veterans Cemetery 2-17-2006 Cheltenham, MD 4 Donation 5 Other (Specify) Funeral service Licencee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Frinsfield, 22955 Hollywood Road, Leonardtown, MD 20650 Jr. M00052 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multi-organ System Due to (or as a consequence of): PSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1□ Yes 2D No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 1 ☐ Yes 2 No 1 npatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DDA 28a. D te f Injury (Month, Day Year) 27. Manper of Deal 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge death occurred at the time date and plane, and due to the datese(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

or Attending Physician: The law requires that the death certificate be executed Box 68760, of Vital Records, P.O.

Funeral

Director

28a-f show

or items 23a or

'natural'

at Hygiene.

Pages 1 and 2 should be fill timent of Health and Mental H tant: If item 27 is marked of

or other traumatic event.

Department of Health ar Important: If item 27 is any injury or other trau

Physician

/Medical

Examiner

burial-transit

use as the

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sete has been signed by the a page 2 should be detached t

After thi

filled in by the

29b. Signature and title of certifier

EB 1

6 2006 FFR 1

the Medical Examiner must be notified at

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

Division death. within 24 hours after death To the Funeral Director: completely filled in by the To the Hospital

State Registrar Truan

29c. License number

29d. Date signed (Month, Day, Year)

P17992

February 10,2006

Name and address of person who completed cause of death (Item 23a) (Type, Print)

South Street Greene

32. Registrar's Signature

31. Date filed (Month, Day, Year)

			For State Registrar	State of	of Maryla		artment <i>tificate</i>		alth and Meath		giene Reg. No.	006	055	37
17			Decedent's Name (First, Middle,	Last)			imouto			2. Date of De	ath		3. Time of	Death
	Physici		Melvin Albert H	lawes						02/01/	2006	Year	7:16	РМ
	/Medic Examin		4a. Facility Name (If not institution, g		ımber)		4b. City, To	own, or Loc	cation of Death			County of Deati		
			Washington Adver	itist Ho	spital		Takor	na Pa	rk		Mor	ntgomer	У	
à	Funeral		5. Social Security Number 6	i. Sex 1⊠M 2□F	7. Age (In yrs	. last birthday)	If Under 1 Months		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	Co.	nplace (State o	_
	Director		577-40-4567		75	Yrs.				01/03/1	931	Wash	ington,	DC
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside Ci	ty Limits
	Mary f ehe	ğ	Maryland Prince	e George	s Bow	ie							1X Yes	2 🗌 No
	r 28a	Director	10e. Street and Number				10f. Zip C	Code			10g. Citiz	en of What Co	untry?	
	death with the Maryland rms 23s or 28s-f show		13901 Old Chape	L Road			207	15			USA			
	d within 72 hours after death with the Marylan jien. r then "naturel", or Items 23s or 28s-1 show to Modicel Exercicel mast by notilited at	Funerai	11. Marital Status	12. Was Dec	edent Ever in torces?	J.S. 13.	Was Deceder	nt of Hispa v Cuban, N	anic Origin? (Sp Mexican, Puerto	ecify Yes or No Rican, etc.)	- 1	4. Race - Ame Black, White		
9	hours after turel; or ite		1 Never Married 2 Married	d 1 Yes	2 🗆 No		1 □ Yes 2		Specify:	,		Specify:	.,	
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<u>ဂ</u>	within 72 ene. then "nal	Completed	15. Decedent's (Specify only highest	grade completed,		(Give	dent's Usual kind of work DO NOT use	done durir	ng most of work	ring	TOD. KIN	o or business/	industry	
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2	be filed htal Hygie od other event, ti	Be C	17. Father's Name (First, Middle, La	ıst)		1		18.	3. Mother's Nam	e (First, Middle			4	
Iand	should be nd Menta marked umatic ev	To B	John Ashbey Haw	2S				S	Sussie I	nez For	ď			
Mar	C1 00 = 00		19a. Informant's Name/Relationship	,					Number or Rur				(ip Code)	
e G	of Health itam 27 other tr		Sandra L. Hawes	/ Former					el Road	Bowie,			Town Chata	
	Pages 1 nent of H int: if its iry or ot		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3			Place of Dispo cemetery, crer	natory or oth	er place)	1			cation - City or		
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90	ficate physics the	edicai	100	d	(1-			2 2						
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ပ်	25 0	Completed	ANGEN	MA						24a. Was auto	DSV	prior to	topsy findings completion of c	available ause of
<u>.</u>	: The		LUNG	CAR	-CW	3WA				1 ☐ Yes	rmed? 2 ☐ No	death? 1 ☐ Yes	2/2 NO	
VIII	sician: The law certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				Other	6. Place of Dea					
<u></u>	Phys r this sral di): To	1 ☐ Yes 2 → Ho 27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time o		c. Injury at	4 Nursing n	ome 5 ☐ Resi 28d. Describe			cify)	
0	nding th. : Afte	tion	1 Aatural 5 Pending 2 Accident investiga	(Moi	nth, Day Year)	Injury	М	Work?	s 2 🗆 No					
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5	tal or	Certification:	Tiomicide	Duile	ding, etc. (Spec	ary)				City Of 10	wii, State)			
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the	e best of my kr basis of examin	nowledge, deat nation and/or in	h occurred at vestigation, i	t the time, on my opinion	date and place, ion, death occur	and due to the red at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s	5)
	ro the within romple comple	Me	29b. Signature and title of certifier	and mai			29c.	License nu	umber		29d. Date	e signed (Mont	h, Day, Year)	
	C > F 0		1/55	Mary.	IM		T	50	1284	4	2	12/2	rol	è
			30. Name and address of person w	no completed cau	ise of death (Ite	am 23a) (Type,	Print)							
	5585		Shamim, Shaid S				e Tako	oma Pa	ark, MD	20912				
	Sta		31. Date filed (Month, Day, Year) FEB 0 7 20		Registrar's Sign	nature	all s							
1	Registr	aı	TLOUIZ	JUU TOO	Action of	100								

Please Type or Print in Black Indelible Ink	. Ensure All Copies Are Legible.
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		,	For State Registrar	State of M	larylan		artment of H		nd Mental Hy	giene Reg. No. 006	05538
	Physici	_	Decedent's Name (First, Middle, Last CATHERINE	st)		Н	OLMES		2. Date of Dea Febru		3. Time of Death 06 6:15 A M
	/Medio Examir		4a. Facility Name (If not institution, given Doctor's Hosp	ital			4b. City, Town, or Lanham				George's
E	Funeral Director			ex 7. A □ M 2(X)F	ge (In yrs. 75	last birthday) Yrs.	ff Under 1 Year Months Days	ff Under 2 Hours	4 Hrs. 8. Date of Birt (Month, Da 02/04/19		orthplace (State or Foreign Country) NC
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD. Prince Ge	eorge's	10c. City	y, Town or Lo	cation				10d. Inside City Limits 1X Yes 2 □ No
	3a or 28a	Funeral Director	10e. Street and Number 9412 Wyatt Drive				10f. Zip Code 20	706		10g. Citizen of What C	Country?
980	n 72 hours after death with the Maryland "natural", or itema 23a or 28a-f show selical Examinations the notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 24 ff Yes, Give Year or Dates	? No		Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	lispanic Origi an, Mexican, Specify:	in? (Specify Yes or No Puerto Rican, etc.)		
21215-0036	d within giene. r than "	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation de com <i>pleted)</i> College (1-40)	5+)	16a. Deced (Give life. Nurs	dent's Usual Occup kind of work done DO NOT use retired ing	ation during most	of working	16b. Kind of Busines	·
land	a la b	To Be C	17. Father's Name (First, Middle, Last) Frank		mons			18. Mother	's Name <i>(First, Middl</i> e, O r	Maiden Sumame) Britt	
Maryland	2 2 2 3	F	19a. Informant's Name/Relationship (11	ng Address (Street Wyatt Dr	and Number	or Rural Route Numbe	er, City or Town, State,	Zip Code)
altimore, I	Pages 1 and ent of Heath nt: if item 2 ry or other		James M. Holmes, Hus 20a. Method of Disposition **Distribution 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State	20b. P	lace of Dispo	sition (Name of natory or other plac am Vetera	1	Date 02/13/2006	20c. Location - City of	or Town, State
Balti	permit. Par Departmen Important: any injury.		21. Signature of Funeral Service Licer				Name and Address Bianchi F.S		pshur St. NW,	, Washington,	DC. 20011
	Physician /Medical		23a. Part 1. Enter the disease, or com shock, or hear failure. List only Immediate Cause (Finaf disease or condition resulting in death)	a	Ace	Je (er the mode of dyin				Approximate Interval Between Onset and Death Impubel
	Examiner	_	Sequentially list conditions,	b. Due to (or a	Ace	ile t	Wmoney	4 6	demo		clary
	and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last				renal	fair	lere		days
8760,	ate be executed hysicien and the burial-transit		Tosuming in doarn, cast	Due to (or a	nel c	alter	ies poni	ercal	ic Conce	N	morell
.O. Box 6	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	23c. If yes, outcom 1☐Live birth 4☐Pregnant 9☐ Unknown	2 Feta	fdeath 3[Ectopic pregnancy Other (specify)	,		23d. Date of d Month	elivery Day Year
Ω.	The law requires that the tee bas been signed by thoage 2 should be detache	Ď	Part II. Other significant conditions of	ontributing to death Encea, Hi		ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribute Yes 2 No 3 1	to the cause of death? Probably 4 □Unknown
Division of Vital Records,		Completed	J	reade.	/ 						
f Vit	8 s p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 X Inpai	ient 2 🗌	ER/Outpatier	t 3 DOA Oth	00	of Death Check only of Sing Home 5 Resident		pecify)
ion o			27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	ury ay Year)	28b. Time o Injury	Wor	yat k? Yes 2 □ N		how injury occurred	
Divis	el or Attendi safter death. i Director: A d in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined	289. Place of the	njury - At ho	ome, farm, str	eet, factory, office		28f. Location (City or Tol	Street and Number or wn, State)	Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one) 1 X Certifying Ph	ysician: To the bes niner: On the basis and manner s	of examina	wledge, death tion and/or in	occurred at the tirvestigation, in my o	ne, date and pinion, death	place, and due to the noccurred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
)	within 2 To the	Σ	29b. Signature and title of certifier	intag m	0		29c. Licens	00-13		29d. Date signed (Mo	11
2	(6)		30. Name and address of person who 6/3 2 LC 31. Date filed (Month, Day, Year)	completed cause of	death (yen	1 23a) (Type,	Print) RA	VIMO	B 5078	2/05/05/05/05/05/05/05/05/05/05/05/05/05/	· WZ
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 8 200	Regis	trar's Signa	turo	L.				

State of Maryland / Department of Health and Mental Hygiene 06 Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 12, 2006 **Physician** MILDRED 7:00 PM ROCHELLE HILL J. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Chapel Oaks Prince George's 1219 Chapelwood Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, March 8, March 8, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Year 936 Washington, DC 1 M 2 XF 69 Yrs. 577-48-3511 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Itams 23e or 28e-f show the Medical Examinar must be notified at 1 XYes 2 □ No Chapel Oaks Maryland Prince George's Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743-6603 1219 Chapelwood Lane USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Tes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Health Aide Government 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) nit. Pages 1 and 2 should be fill artment of Health and Mental Highent: if Item 27 is marked oth injury or other treumetic even injury or other treumetic even Elizabeth Beatrice Jackson Lawrence Washington Sharp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1219 Chapelwood Lane Chapel Oaks, MD Tymira R. Sharp Daughter 20743-6603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Riverdale Park Crema. 2-14-06 * 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, MD 22. Name and Address of Facility Jordan Funeral Service, Inc. Departr Departr import eny inju 21. Signature of Funeral Service Licensee 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer 1.5 Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sicien and burial-transit the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, attending physicien as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month ō Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time ot death ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1X Yes 2 No 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 N Residence 6 Other (Specify) P 1 Yes 2 XNo the Funeral Director: After the pletely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospitei or Attending within 24 hours after death. To the Funerel Director: After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide City or Town, State) 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month. Dav. Year) February 13, 2006 D0060050 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahrukh M. Hussain, MD 1221 Mercantile Lane Largo, MD 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FEB 13 200S

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiefie [] [] 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year William Richard Huddleston, Jr. **Physician** 11:00 a^M Feb. 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 507 Bayberry Drive Severna Park Anne Arundel 8. Date of Birth (Month, Day, Year)
Apr. 21, 1 If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 M 2 □ F Months Davs 163-44-3523 50 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 23a or 28a-f ehow other treumatic event, it a Midical Examiner must be notified at MD Anne Arundel Severna Park 1 ☐Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 507 Bayberry Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? , or itame 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done du life. DO NOT use retired) during most of working Northrop Grumann permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other treumatic event, tra Ma Elementary/Secondary (0-12) College (1-4or 5+) Corporation Payroll Manager 4 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) William Richard Huddleston Lois Lawton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 507 Bayberry Drive, Severna Park, MD 21146 Ellen Barrie Huddleston/Wife Feb. 4, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal Irom State Baltimore, MD Metro Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death and Death Immediate Cause (Final disease or condition resulting in death) Physician 12 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner sician and burial-transit Due to (or as a consequence of) ed by the attending physician detached for use as the burial Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. I 1 Yes 2 No been signed by t should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No

Division of Vital Records, filled in by the funeral director, this e or Attending F Director: After To the Hospitel o within 24 hours aft To the Funerel Di

28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peninsula Farm Rd Memberlain, My 6

3□ DOA

28c. Injury at Work?

1 Tes 2 No

28d. Describe how injury occurred

State Registrar

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31. Date filed (Month, Day, Year)

5 Pending investigation

6 ☐ Could not be

1 Inpatient

28a. Date of Injury (Month, Day Year)



2 ER/Outpatient

28b. Time of

Certification; To

Medical

27. Manner of Death

1 Anatural

2 Accident

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** FEBRUARY 12 2006 5:00PM NORA FRANCES TAYLOR HOWELL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 205 GOLDSBOROUGH ST. EASTON TALBOT If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 X Yrs. 214-18-4710 Director 82 APRIL 9 1923 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show treumatic event, the Medical Examinar must be notified at 1XYes 2 □ No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? itams 23e 205 GOLDSBOROUGH ST. 21601 TISA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or item any injury or other treumatic event, the Market and Once. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AGENT REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM NORMAN TAYLOR CATHERINE MORRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA H. RASMUSSEN/DAUGHTER 8 HAZEL ROAD, HOPKINTON, MASS 01748 20a. Method of Disposition

1♣ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State SPRING HILL CEMETERY 2/16/2006 * 4 □ Donation 5 □ Other (Specify) EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JOHN Z MERCERO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Pnysician vear /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or sarrying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician P.O. Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į in the past 12 months? Month Day Year 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 PNo Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred I or Attending P after death. After 1 Natural 5 Pending Injury after death.

Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funerel D 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number 29d. Date/signed (Month, Day, Year) nd title of cert 13/010 30. Name and Iddress of person who completed cause of death (Item 23a) (Type, Print) (ID 29466 PINTAIL DR. EASTON, MD 21601 DAVID SMITH M.D. gistrar's Signature State 1 4 2006 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 0 6 05542

			1 - For State Registrar		(Certificate of	Death	Re	g. No.	000%	6_
	4.7	-92	1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month		3. Time of D	eath
	Physici /Medic		Carole Ann	Henley				Februar	y 1, 200		M
	Examin		4a. Facility Name (If not institution, give				r Location of Dea		4c. County of D		
1.77	Service By		Calvert Memor				Freder			lvert	
43	Funeral Director		216-40-6602	9x □ M 2⊠F 7. Age (In) 64	rs. last birthe	Months Davs	If Under 24 Hr Hours Mir		Year) 9. E 1941 Wa	Birthplace (State or Country) Shington	Foreign , DC
	and		Usual Residence of Decedent 10a. State 10b. County	10c	City, Town	or Location				10d. Inside City	Limits
	Mary	to	MD Calv	ert	Lusby	7				1 ☐ Yes 2	2 🔯 No
	1 the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?	
	38 o	0	1130 Stagecoach	Trail		2	0657		USA		
	deat	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	n U.S.	13. Was Decedent of H	Hispanic Origin? (Specify Yes or No-	14. Race - A Black, W	merican Indian,	
020	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mential Hygiene. Item 27 ie marked other then "naturel; or iteme 23a or 28a-f ehow other treumatic event, the Mudical Exames must be motified at	þ	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No			_	White	
ה ה	72 h	Completed	15. Decedent's Ed (Specify only highest gra		(4	ecedent's Usual Occup Give kind of work done	during most of w	orking 1	6b. Kind of Busine	ss/Industry	
7	nithin Pen	id III	Elementary/Secondary (0-12)	College (1-4or 5+)		ife. DO NOT use retire	d)	_	O1 - 4-1-4		
V	dygien ther t	S	12 17. Father's Name (First, Middle, Last)		IVIE	nager	18 Mother's N	ame (First, Middle, M	Clothing	g Store	-
	ntal h	Be		Radtke							
ج	should nd Men marke	T ₀	Edward Albert 19a, Informant's Name/Relationship (7)		19h A	Mailing Address (Street		ret Newel		e Zin Code)	
<u>⊽</u>	d 2 s th an t7 ie treui			** * *		54				2	
บ์	Heal Heal tem 2		Larry Henley (hus 20a. Method of Disposition		b. Place of D	Stagecoa Stagecoa Sisposition (Name of			MD 2065 Oc. Location - City		
<u> </u>	ages ant of it: if i		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		-	riematory or other pla Hill Cemet	'		Suitland	M	
altimor	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tre		21. Signature of Funeral Service Licen		Ceuar			Lee Funera			Δ
Ď	Departition Departition Departition Departition Departition Department of the Depart		Gary J. Goff	>		8125 South					
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the	leath. Do no					Approximate Interval Between	
	Physician		Immediate Cause (Final	Plane	100	10 FB A				Onset and De	
	/Medical		disease or condition resulting in death)	Due to (or as a cen	sequence of					Lycoru	-)
	Examiner		0	b							
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	sequence of	:					
	nd nd transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
Š,	e exe den a urial-		resulting in death) Last	Due to (or as a con	sequence of	1					
00/00	ntificate be executed ing physicien and a as the burial-transit	Medical		d							
_		-	IF FEMALE:	23c. If yes, outcome of pre	ananau						
o o	The law requires thet the death ce tte has been signed by the attendi age 2 should be detached for use	hysiclan/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 1 4 Pregnant at time	etal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of Month	- '	9ar
j	the de	yslo	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	or death	J Other (specify)					
ŗ	thet i	0	Part II. Other significant conditions of	ontributing to death but not	resulting in t	he underlying cause giv	ven in Part I.	23e. Did tob	acco use contribute	e to the cause of de	ath?
3	uires n sign	d by						1 ☐ Ye	s 2 🗆 No 3 🗀	Probably 4 Ur	nknown
ecords	w requir been si should	Completed						24a. Was an	24b. Were	autopsy findings av	vailable
ב	he la e has age 2	E C						autopsy	ed death	autopsy findings av to completion of car 1?	use of
NI G		Ö	25. Was case referred to medical				26 Place of D	1 ☐ Yes 2 eath <i>Check only one</i>	-	′es 2□ No	
	ysici is cer direct	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ER/Outp	atient 3 DOA Ott		Home 5 ☐ Resider		(pecify)	
5	ig Ph ter th neral		27. Mannar of Death	28a. Date of Injury (Month, Day Yea				28d. Describe hor		, , , , , , , , , , , , , , , , , , ,	
20	andin ath. or: Af	atlo	1.☑Natural 5 ☐ Pending 2 ☐ Accident investigation	1	7		Yes 2 □No				
<u> </u>	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farn	n, street, factory, office		28f. Location (Str City or Town,		Rural Route Numb	er,
2	itei o rrs aft rel Di led in	Ce									
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certification of the funerel Director: After this certification in the funerel director.	edical	29a. Certifier 1/ Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of exar and manner stated.	knowledge, nination and/	death occurred at the ti or investigation, in my o	me, date and place ppinion, death occ	ce, and due to the ca curred at the time, da	use(s) and manner te and place, and	as stated. due to the cause(s)	
	To ti Withi To ti	M	29b. Signature and title of certifier			29c. Licens			d. Date signed (M		
			I NIWX			Pi	13304	,	2/2/00	0	
	in		30. Name and address of person who	completed cause of death	(Item 23a) (T	ype, Print)					
	10		Charles W. Benn			. Trueman	Road Lu	sby, MD	20657		
100	Sta		31. Date filed (Month, Day, Year)	32. Registraris S	ignature	4 Rock	р				
	Registr	ar	FEB -	6 2006 Ac	145.1 1	1. ROGER					

Κ.				Type or Print in Bia					•		_		
IDR	EY HAR	ROI		State of Maryland	-				Mental Hy	gien	2006	055	1.3
			1 - State Registrar		Cer	tifica	te of l	Death		Reg. No	. U U U	000	7 0
			1. Decedent's Name (First, Middle, Las						2. Date of De Month	ath Da	y Year	3. Time of	Death
	Physic /Medi		Audre	y Harrod						31,	2006	0837	A ^M
Die	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or	Location of Death	1	40	. County of Death)	
			801 WINTERS LANE	APT. 429		CAT	CONSV	ILLE			BALTIMOR	E	
	Funeral		Social Security Number 6. Se	7 M OF T		If Unde	or 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb. 10	th y, Year	9. Birth	place (State o	r Foreign
	Director		210 00 1/00	[™] 2√ F 70	Yrs.				Feb.10	,19	35 Mar	yľand	
	put *		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	cation						10d. Inside Ci	ty I imits
	eho	5			01111 01 20		C - L -					1 🗆 Yes	*
	Ne N	Directo	Maryland Balti	шоте				nsville	:	10a C	itizen of What Co	untru?	
	with t	ā	801 Winters Lar	ne Apt. 429		101. 2	ip Code 21	228		rog. C		S A	
	within 72 hours after death with the Maryland ene. then "naturet, or items 23s or 28s-f show the Medical Examiner must be notified at	Funeral	44 Marial Classes	12. Was Decedent Ever in U.S.	12 1	Nas Dec			pacify Vac or No		14. Race - Amer		
	ter d	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	13. 1	f Yes, sp	ecify Cuba	ispanic Origin? (S In, Mexican, Puerl	o Rican, etc.)		Black, White		
99	rs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	I □ Yes	2X No	Specify:			Specify: B1 a	ack	
ğ	thor sture	e	15. Decedent's Edi	ucation 1	6a. Deced	ient's Us	ual Occup	ation		16b.	Cind of Business/l	ndustry	
<u> </u>	n n n n	pie	(Specify only highest grad	de completed) College (1-4or 5+)	(Give . life. L	kind of w DO NOT	ork done d use retired	during most of wor	rking	Ca	meone 1	71 00 0	
2	r the	E	Elementary/Secondary (0-12)	College (1-401 54)	D	ome	stic			Ħŏ	meone i	rise s	
힏	othe	Be Completed	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle	, Maide	n Surname)		
<u>ਕ</u>	lid by fenta	To B	Roosevelt	Ric	e			Charlo	tte		Freela	nd	
Maryland 21215-0036	should be made	1	19a. Informant's Name/Relationship (T			•					or Town, State, Z		
Σ	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or tiems 23a or 28a-f show eny injury or other traumetic event, the Medical Examiner must be notified at ence pince.		Forlisa Washir	ngton/Niece	280	Sho	re A	cres Wa	y #148	Pr	ince F	red.MD	2067
altimore,	of He ttem		20a. Method of Disposition	20b. Place ceme	e of Dispos etery, cren	sition (Na	ame of other plac	(e)	Date	20c. L	ocation - City or	Town, State	
Ē	Page nent nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Brow	wn's	С́е	mete	ry 2/4/	2006	Por	t Repul	olic,	MD
<u>=</u>	mit.		21. Signature of Funeral Service Licens	600	22	. Name a	and Addre	ss of Facility	ewell	Fun	eral Ho	ome	
m	9 9 E 9		Blady a.	Sewell	14	51	Dare	s Beach	Rd. P	rin	ce Fred	1.,MD2	0678
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death.	Do not enti	er the mo	ode of dyin	g, such as cardia	or respiratory a	rrest,		Approximat Interval Bet	e ween
	Physician		Immediate Cause (Final	a Hypertensive oth		1.	N . 1	a denina	or Marc	11.		Onset and	
	/Medical		disease or condition resulting in death)	a. Typerten swe QL Due to (or as a consequent	<u>e.//O.S.C.</u> ce of):	un	one (watera	occitor	ans	-20186		
	Examiner			L. Committee									
		e	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ce of):								
	cuted nd ransi	Examiner	that initiated events	С.									
,09	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequen-	ce of):								
~	eath certificate be executed attending physician and for use as the burial-transit	cai		d									
P.O. Box 68	The law requires that the death certificate ate has been signed by the attending physionage 2 should be detached for use as the	Physician/Medic	IF FEMALE:	*									
õ	th ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de		Ectopic	pregnancy			- 6	23d. Date of deli Month	•	Year
E	e dea he at hed fo	Sici	1 ☐ Yes 2 DNo	4☐ Pregnant at time of death 9☐ Unknown	n 5[Other (s	specify) _				WOITH	Day	eai
<u>م</u>	w requires that the de been signed by the s should be detached	Phy	9 Unknown					. 5 . 1	ana Did		use contribute to	45.00.00.00	44-2
Ś	igne bed	þ	Part II. Other significant conditions co	intributing to death but not resulting	ng in the ur	nderlying	cause giv	en in Part I.			n) n	the cause or o	
0.0	een s	ted	cancer						10	Tes a	2 NO 3 WE	Doably 4 Li	/IIKNOWN
O O	law lasb	ple							24a. Was	psy	prior to d	topsy findings completion of c	available ause of
<u> </u>	The ete h page	Completed							perfo	ormed?	o death?	2 No	
<u>ita</u>	Attending Physician: or death. ector: After this certifice by the funeral director, p	Be	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only	one)			
<u>~</u>	hysic his o	ပ္	1 ☐XYes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatien			4 Nutsing r			6X Other (Spec	enfy) AT	SCENE
u	ng P fter t inera	i.	27. Manner of Death 1 2 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28	b. Time of Injury		28c. Injur Wor		28d. Describe	how inj	ury occurred		
<u>s</u>	eath.	catl	2 ☐ Accident investigation			М	1 🗆	Yes 2 □ No					7
Division of Vital Records,	irect irect	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, facto	ry, office		28f. Location (City or To		and Number or Ru te)	ral Route Num	ber,
	urs a	ပိ											
	To the Hospitel or Attending Physiclan: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Exam	rsician: To the best of my knowle iner: On the basis of examination									i)
	the the	Med	one) A	and manner stated.		2	9c. Licens	a number		:304 D	ate signed (Monti	Day Voor	
	N N N		29b. Signature and title of certifier	7				C.M.E			FEB. 1, 2		
•			- Court !	le est up		1							
	ı		30. Name and address of person who o	0 111	Ba) (Type, PF:Ni	Print) V STI	REET	BALTIMO	RE. MAR	YT.AN	m 21201		
	, 		Tasha Z Circl Noer	- ([, 1] ,			-		,				
	St Regist	tate trar	31. Date filed (Month, Day, Year)	2 2006 Addison	K	40	we						
				, ,		0 1							

			State of Maryland / Department / Department / Department / Department / Department / Department	artment of Health and M rtificate of Death		2006 05544
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia		KENNETH WILLIAM HARMAN		February	7, 2006 3:02 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Examin	er	7137 Sundays Lane	Frederick		Frederick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign Country)
	Director		705–10–5936 1XM 2□ F 92 Yrs.	Months Days Hours Min.	October	Year) Country) 21,13 Maryland
	P .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L.			10d. Inside City Limits
	anylar show	-	10a. State 10b. County 10c. City, Town or L Maryland Frederick Freder			1 ☐ Yes 2X No
	Ba-f	Director		10f. Zip Code	100	g. Citizen of What Country?
	with ti	Dir	10e. Street and Number 7137 Sundays Lane	21702		nited States
	s 23g	Fra	-			14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show importent: If item 27 is marked other than "naturel", or Items 20 is not item in the Invited at environment injury or other treumatic event, Its Medical Evanit at must be invited at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White, etc. Specify: White
21215-0036	2 hou	Completed by		dent's Usual Occupation	10	6b. Kind of Business/Industry
72	7 nin 7	ple	life	kind of work done during most of work DO NOT use retired)	ang	
5	d with giene granthe	E O		eman		Railroad
b	e file al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	
<u>la</u>	uld b Ventz rrked ric e	ToE	Charles William Harman	Elsie	Mae	McAfee
Maryland	2 sho and is mu		, , , , , ,	ng Address (Street and Number or Ru		
2	and ealth m 27			Sundays Lane / F:		
ore	ges 1 r of H If ite		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	matory or other place)		0c. Location - City or Town, State
Ë	ment tent: jury					ewistown, Maryland
Baltimore,	permit Depar Impor eny in		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Sta 104 E. Main St. /		
			23a. Part. For the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.			IIILEI VAI DELWEET
	Pnysician	0.9	Immediate Cause (Final disease or condition	enotice Candiova	scular	Pisersz gnset and Death
	/Medical		resulting in death) Due to (or as a consequence of):			
	Examiner		Sequentially list conditions, b.			
	D tis	Examine	if any, leading to immediate cause. Emer Underlying Cause (Disease or injury			
	and and I-tran	хап	resulting in death) Last C			
8760,	cate be executed physician and the burial-transit	aiE				
687	icate phys s the	edicai	d.			
Box (death certific e attending p id for use as	iclan/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
O.	that the d ed by the detached	Physi	9 Unknown			
S, D	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the cause of death?
rd	w require been sig should b				1 Tes	s 2 No 3 Probably 4 Hinknown
of Vital Record	ne law has b ye 2 sl	ompleted			24a. Was an autopsy perform	prior to completion of cause of
ita	sicien: Th certificate irector, pag	Se C	25. Was case referred to medical	26. Place of Dea	ith (Check only one	9)
\ \	S S	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ont 3 DOA Other: 4 Nursing H	ome 5 Resider	nce 6 Other (Specify)
			27. Manner of Death 1 ✓ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work?	28d. Describe how	w injury occurred
<u>S</u>	Attending or death.	atle	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division	Il or Attend after death Director: /	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Str. City or Town,	reet and Number or Rural Route Number, , State)
	urs af			Ab and mod of the time of the and	and door to the	upo(a) and manner as stated
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal of the control of the	ith occurred at the time, date and place nvestigation, in my opinion, death occu	rred at the time, da	ite and place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Month, Day, Year)
	/		> // 7 /ha ms	00035152		2-1.00
	5		30. Name and address of person who completed cause of death (Item 23a) (Type 5 - L / / ANT, MD 100	S. Center Sp.	Thurmon	- MO 21786
	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 9 2006 32. Signature	DO035152 S. Cevren Sp. 7		

			Flease i	State of Mandar				•	_	
			For State Registrar	State of Marylar		rtificate o			2006	0551.5
			Registrar 1. Decedent's Name (First, Middle, Last))	001	illicate o	Death	2. Date of Deat	n Noi-	3. Time of Death
ш	Physici	an						Month	Day Year	
	/Medic		Peggy Sue Hudd			4b. City. Town	, or Location of Deat		4c. County of Deal	
1	Examin	er	Fort Washington				Washingt		Prince (
	Funeral		5. Social Security Number 6. Sec		last birthday)	If Under 1 Ye	ar If Under 24 Hrs	8. Date of Birth		hplace (State or Foreign
н	Director		212-88-0845	^{3 M 2} X ^F 36	Yrs.	Months Day	/s Hours Min.	March	10,1969	Maryland
	P		Usual Residence of Decedent	100 0	ty, Town or Lo					10d. Inside City Limits
	ehow	_	10a. State 10b. County		•					1 ☐ Yes 2X No
	Ba-f	Director	Maryland Charles		Byrans	10f. Zip Code			0g. Citizen of What Co	
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ehow Ite Madical Examinat must be notilied at		10e. Street and Number							only:
	s 234	Funeral	2332 Woodberry Dr	1VE 12. Was Decedent Ever in U	IS 13		616 of Hispanic Origin? (5	Specify Yes or No-	U.S.A.	incan Indian,
	lterr Iterr	Ë	1 Never Married 2 Married	Armed Forces?		If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer	to Rican, etc.)	Black, Whit	e, etc.
936	urs al	5	3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1□Yes 2\X	No Specify:		Specify: Wh	ite
21215-0036	2 hor	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Oc	cupation ne during most of wo	rking	16b. Kind of Business.	Industry
21	thin 7	pig	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	ired)	9		
	filed wi Hygien Sther th	ပ်	10		Secre	tary			Flooring C	ompany
nd	be file d oth	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,		
y a	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Ma	၉	William T. Farre					. Alliso		7:- 0
Maryland	12 sh h and h and 7 is m		19a. Informant's Name/Relationship (T) Donald C. Huddle			•			r, City or Town, State, . ad, Md. 20	
	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23e or 28e-1 ehow other traumatic event, the Madical Examinar rust be notified at		20a. Method of Disposition			osition (Name of		Date	20c. Location - City or	
Baltimore	0 0 = 5	-	1 XBurial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, cre	matory or other	^{olace)} Feb. 7	7, 2006	Waldorf, M	
턡	permit. Pag Department Important: I any injury o		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 				1 Gardens			aryrana
Ba	permit. Departr Importa any inje		10m 10 .1	M0066	8 🕅	illiams	funeral F	Iome, P.A	· Hood Md	20640
			23a. Part1. Enter the dilease, or comp shock, or hearth illure. List only o		- 4	ter the mode of	dying, such as cardia	c or respiratory arr	Head, Md.	Approximate Interval Between
	Piles in Labour		Immediate Cause (Final	ne cause on each line.	100		cer			Onset and Death
4	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse	guence of):	Carr				Zyeens
	Examiner				. ,					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cone a	quenos or):					
	cuted nd ransi	Examiner	that initiated events	c						
760,	e be executed sician and e burial-transit		resulting in death) Last	Due to (or as a conse	quence of);				- 11	
876	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai		d						
x 68	that the death certificate ed by the attending phys detached for use as the	Mec	IF FEMALE:	23c. If yes, outcome of pregr	anov				23d. Date of de	lives.
Вох	ath c attend for us	ian	in the past 12 months?	1 Live birth 2 ☐ Fet 4 Pregnant at time of	al death 3[☐Ectopic pregna ☐ Other (specify			Month	Day Year
P.O.	he de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unknown	30	_ Citiel (specify	/			
	res that t igned by be deta	Completed by Physician/Medi	Part II. Other significant conditions co	ntributing to death but not re	sulting in the t	inderlying cause	given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
sp	uires 1 sign Ild be	d b						1 □ Y	es 211No 3 P	robably 4 Unknown
S	w require been signal	lete						24a. Was	an 24b. Were a	utopsy findings available
Re	Physician: The lav this certificate has al director, page 2	m o						autop perfor	med? death?	completion of cause of
tal		Be C	25. Was case referred to medical				26. Place of De	ath (Check only o		
2	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 €	ER/Outpatie	nt 3 DOA	Other: 4 Nursing	Home 5 Resid	ence 6 Other (Spe	acify)
0	ng Ph ter th neral	ü	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. I	njury at Work?	28d. Oescribe h	ow injury occurred	
<u>5</u>	endir sath, or: Af he fu	atic	2 Accident investigation				1 ☐ Yes 2 ☐ No			
Division of Vital Records,	ter de irect	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, st ify)	reet, factory, off	ice	28f. Location (S City or Tow	itreet and Number or F n, State)	tural Route Number,
Ω	urs at	S							(2) 224 224 224	
	Hosp 24 ho Fune Fune	lica	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exem	rsician: To the best of my kn iner: On the basis of examin and manner stated.	nowledge, dea nation and/or in	th occurred at th nvestigation, in n	e time, date and plac ny opinion, death occ	e, and due to the turred at the time,	tause(s) and manner a date and place, and du	e to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	Medical	29b. Signature and title, of certifier	and married Stated.		29c. Lic	ense number		29d. Date signed (Mon	th, Day, Year)
)	F 3 F 8		1-1-1	1. 1		-	325200		7 - 7 . 7	000
1			30. Name and address of person who d	completed cause of death (Ite	m 23a) (Tvna	Print)	12010			Thington MD
1	85		H. Herbert Wa	Thinaton &	1 Ch	17-01	wingston	Rd # 209		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	1 4.	9			
	Regist		FFR 0.8	2008 Mercus	15. K	parce				

DHMH 17 Rev 1/2001

				For State	State of M	Maryland		rtment of H		Mental Hy	211	06	05546
			7	Registrar 1. Decedent's Name (First, Middle,	, Last)	<u> </u>		inicate or i	Deatri	2. Date of D	Reg. No.		3. Time of Death
	0.00	Physici /Medic	al	Clara	Viola	Hughe	es	th City Town o	L continue of Donat	Feb	Day	Year 2000 unity of Death	
		Examin	er	4a. Facility Name (If not institution,	11	, 111		4b. City, Town, of	Location of Deat				
				5. Social Security Number	6. Sex 7. A	Age (In yrs. las	Cale	If Under 1 Year	If Under 24 Hrs	8. Date of Bi	rth	altimo	
	100 S	Funeral Director		220-12-3944	1 □ M 2 □ XF	84	Yrs.	Months Days	Hours Min.	(Month, D	y = 1,19	2.2 Mz	hplace (State or Foreign untry) aryland
	45	9		Usual Residence of Decedent									
		arylar show d.at	_	10a. State 10b. County		10c. City,	Town or Lo						10d. Inside City Limits 1 X Yes 2 □ No
		death with the Maryland me 23a or 28a-f show rmust be notified at	Directo		imore				imore		10-01		
		with ti	Dire	10e. Street and Number				10f. Zip Code	_		10g. Citizen		•
		eath	eral	4300 Miami	I Place 12. Was Deceden	nt Ever in U.S.	13. V	2120		pecify Yes or N		ed Sta Race - Ame	ates ncan Indian.
		ther d	Funeral	1 Never Married 2 Marri	Armed Forces	5?		Vas Decedent of H Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)		Black, White	e, etc.
	036	urs al	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates	_	1	☐ Yes 2 🛣 No	Specify:		Spe	ec <i>ify:</i>	Black
	Maryland 21215-0036	72 ho	Completed	15. Decedent' (Specify only highes			16a. Deced	ent's Usual Occup	ation during most of wo	rkina	16b. Kind o	f Business/	Industry
	7	ithin	mple	Elementary/Secondary (0-12)	College (1-4o	r 5+)		kind of work done OO NOT use retired	d)	3			
	2	iled w Hygiei her ti		12 17. Father's Name (First, Middle, L	(act)		Нс	memaker	18. Mother's Na	me /First Middle		wn Hon	ne
	anc	ntal h	Be	Jarred Jan						nnie Wi		name)	
	2	should nd Me mark matic	2	19a. Informant's Name/Relationsh			19b. Mailin	g Address (Street				wn, State, Z	Zip Code)
	S	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "netural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ance.		Wayne Hughes			703 9	South Woo	dington	Road. B	altimo:	re. MI	21229
	Baltimore,	s 1 a f Hea ltem otha		20a. Method of Disposition			ce of Dispo:	sition (Name of natory or other place	1	Date			Town, State
	Ë	Page nent c int: If		1 Burial 2 Cremation 4 Donation 5 Other (Sp		10		s Cemete		-2006	Oakle	y. Mai	cyland
	alti	permit. Departri Imports eny inju		21. Signature of Funeral Service L	icensee	The same							ome, P.A.
	<u>m</u>	89 = 89		Kyle S. Si	imons	M01206	22	955 Holl	ywood Ro	ad, Leo	nardto	wn, M	20650-0279
	7			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cause only one cause on each	ed the death. line.	Do not ente	ar the mode of dyin	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
		Physician		Immediate Cause (Final disease or condition	_ Athe	roscu	DHG (Cardiova	sculan H	eart D	scase	,	VIDOS
	4.	/Medical Examiner		resulting in death)		as a conseque							
	- 12		3	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	b	as a conseque	nce of):						
		nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	K	.0 4 0000400							
	~	execunand and all-tra	Exal	resulting in death) Last	c. Due to (or a	as a conseque	nce of):						
	68760,	certificate be executed ding physician and se as the burial-transit	cal		L d								
		tificat ng phy as th											
S	ŏ	th cer endir r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnand 2 Fetal d		Ectopic pregnancy	,		23d.	Date of del	,
9	Ö.	e dea the att	sici	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		at time of dea		Other (specify)				Month	Day Year
3	, <mark>Ф</mark> .	nat the d by th letache	Phy	Part II. Other significant conditio	une contributing to death	but not recult	ing in the	dorbina aguas au	on in Bort I	23a Did	tobacco use	contribute to	the cause of death?
2	ds,	requires that the death certifics een signed by the attending ph hould be detached for use as t	d by				ing in the di	idenying cause giv	en er rait i.		Yes 2 N		
2	ecord	× 4 5	Completed	Aspiration P).					24a. Wa	s an 2	4h Were au	itonsy findings available
1	Re	8 CA	дшc	napiration P	neumonia					aut	formed	death?	utopsy findings available completion of cause of
	ta	Physician: The land this certificate had director, page	e Cc	25. Was case referred to medical					26 Place of De	1 ☐ Yes ath (Check only		1 🗆 Yes	21 No
2	of Vital	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpa	tient 2 BE	R/Outpatien	t 3 DOA Oth	0.00	Home 5 ☐ Res		Other (Spe	cify)
		ling Phys n. After this funeral di		27. Manner of Death	28a. Date of In		8b. Time of	28c. Injur		1	how injury or		
2	<u>S</u>		atic	Natural 5 Pending	gation		,,		Yes 2 □No				
	Division	after de Direct	Certification:	3 Suicide 6 Could n 4 Homicide determi	inod 200. Place of I	Injury - At hom etc. <i>(Specify)</i>	e, farm, str	eet, factory, office		28f. Location City or T	(Street and Nown, State)	umber or Ru	ural Route Number,
(-)		urs al											
W 1		To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier Check only one) Certifying Check only	g Physician: To the bes Examinar: On the basis and manner:	of examination	n and/or inv	estigation, in my c	me, date and plac opinion, death occ	e, and due to th urred at the time	e cause(s) and , date and pla	manner as	stated. to the cause(s)
4,	`	o the	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date si	gned (Mont	h, Day, Year)
		->-0		I dana Ma	in MD.			Do	560	72	Febru	ari	7,7006
				30. Name and address of person v	who completed cause of	f death (Item 2	23a) (Type,	Print)	Rayhir	2000	nand	200	717.7.9
		- Sta Registi	ite ar	30. Name and address of person vectors and address of person vectors and address of person vectors and address of person vectors. 31. Date filed (Month, Day, Year)	3 1 3 2006	stra s Signatu	re A	Speed)			- u	_, /
	(19.26)							-					

		-	For State Registrar	State	of Marylan		artmen <i>tificat</i>			Mental Hy	giene Reg. No.	006	0551	47
Ш			Decedent's Name (First, Middle, L.	ast)						2. Date of De Month	ath Day	Year	3. Time of D)eath
	Physicia /Medic		GLADYS L	. HUB	BARD					FEB.		2006	6:10	РМ
	Examin		4a. Facility Name (If not institution, g	ive street and nu			4b. City,	Town, or	Location of Deat	th		County of Dea		
			Randolph Hill					Whea	ton If Under 24 Hrs	8. Date of Bir		ONTGO		Foreign
	Funeral		5. Social Security Number 6. 220-05-6246	Sex 1 □ M 2 □ F	7. Age (In yrs. 95	Yrs.	Months	Days	Hours Min	(Month, Da	iy, Year) 13 , 1	910	thplace (State or ountry) Virgini	ia
	Director	-	Usual Residence of Decedent		93					Dec.	17,1	710	VIIGIII	La
1	ehow		10a. State 10b. County		10c. Cit	y, Town or Lo							10d. Inside City	
	a-f-	ctor	MD Mont	gomery		Si	lver	Spr	ing				1 🗆 Yes	2× No
1	or 28	Director	10e. Street and Number		-		10f. Zip					en of What C		
-	23a	rai	1808 Marym			- 1.0		209		34 V		U.S.A		
1	item item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed F		.5.	Yas Dece	cify Cubai	n, Mexican, Pue	Specify Yes or No to Rican, etc.)	,	Black, Whi		
5	Ir. or	by F	3√2 Widowed 4 □ Divorced	If Yes, G	aFNo live Dates:		1 🗆 Yes	2 No	Specify:			Specify: B	lack	
5 ;	be hied within 72 nouts atter death with the Maryland to the tipen "Let with the treatment" or iteme 23s or 28s-f show event, if a Modical Examinar must be notified at		15. Decedent's	Education	"	16a. Deced	dent's Usu	al Occupa	ition Juring most of we	ndkina	16b. Kir	nd of Business	s/Industry	
7	en "n	Completed	(Specify only highest of Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT u	se retired,)	,,,,,,,,,		a a-		
١.	ygien ygien t. E.	5	6th]	Hous	ekee	ping	ma /Cime Adiaballa	1		vernmer	10
	be title H off off	Be	17. Father's Name (First, Middle, La	st)						me (First, Middle 'Y Hawk	_	Sumame)		
<u> </u>	should and Men amarke	P	John Jones 19a. Informant's Name/Relationship	(Tuna Print)		19h Mailir	na Address	s (Street a		y nawk Iural Route Numb		r Town, State.	Zip Code) 2 (0906
	d 2 st th and 7 is r traur		Elsie Fleming		e)		-			Ln, S				1900
บ์	permit. Pages I end 2 should be lited within /2 hours after death with the warylat Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department is I ferm 27 is marked other than "netural", or iteme 23a or 28a-f ehov any injuries other traumatic event, the Modical Examinariment by notified at once.		20a. Method of Disposition			Place of Dispo				Date		cation - City o		
2	Pages nent of I		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		n State I	ncoln			1 .	1/06	Roc	kvill	e, MD	
	permit. Page Department of Important: If any injury once.		21. Signature of Porleral Service Lice						-	NOWDEN				P.A.
ŏ	Depar Impor any in		GCOME.	K.A.	Low	tleg2.	46 N	. Wa	sh. St	., Roc	kvil	le, M	D 20850)
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	omplications that	caused the deat	h. Do not ent	ter the mod	de of dyin	g, such as cardia	ac or respiratory	arrest,		Approximate Interval Bety	ween
F	Physician		Immediate Cause (Final disease or condition	-		clero	tic	Cere	brovas	cular	Dise	ase	Onset and D	eath
	/Medical		resulting in death)		o (or as a consec		<u></u>	002	222014					
	Examiner	_	Sequentially list conditions,	b	Ur as a consec	was at							-	
	sit s	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(UT as a CUISOL	paanca or).								
	xecut and al-trar	xan	that initiated events resulting in death) Last	c. Due to	o (or as a consec	quence of):							-	
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200	ificate g phy: as the	edic		u										
ŏ	leath certific ettending p i for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		DEctopic p	regnancy				23d. Date of d	•	
מ	death	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No		gnant at time of o		Other (s					Month	Day Y	rear
r S	at the	h,	9 Unknown					_	1.5.1	an Did	tehonon :	.aa aaatsibuta	to the cause of d	loath?
<u>ທ</u> ົ	iaw requires that the de as been signed by the c 2 should be detached	۵	Part II. Other significant condition			sulting in the u	inderlying	cause give	en in Part I.		Yes 2		Probably 4 🛣	
cords	requii	ted		ension	1							1		
ပ္သ	heiaw hesb je2st	Completed	Dement	ia						24a. Wa aut	s an opsy formed?	24b. Were prior to death	autopsy findings a completion of ca	available ause of
	pag pag	ပိ								1 ☐ Yes	2×2×10		es 2□No	
VItal	Physician: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	7	3500:		Oth	00	eath (Check only		e Dothar (S		
	Phys rthis raldi	.: To	1 Yes 2 No	1	☐ Inpatient 2 ☐ e of Injury onth, Day Year)	28b. Time o		28c. Injur Wor		Home 5 Res			эвспу)	
0	Attending it death. ector: After by the fune	ţi	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		onth, Day Year)	Injury	М		k? Yes 2 □No					
DIVISION	ai or Attending Physicien: • after death. I Director: After this certific d in by the funeral director,	ifica	3 Suicide 6 Could no 4 Homicide determin	288. Pla	ce of Injury - At I	nome, larm, st	reet, facto	ry, office		28f. Location City or T	(Street an	nd Number or	Rural Route Num	ber,
5	tai or s afte el Dir ed in	Certification:	4 - Normoles	56	iding, oto. (Opoor									
	To the Hospital of whithin 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier 1	kaminar: On the	he best of my kn basis of examin anner stated.	owledge, dea ation and/or ir	th occurred avestigation	d at the tir n, in my o	ne, date and pla pinion, death oc	ce, and due to th curred at the time	e cause(s) e, date and) and manner d place, and d	as stated. ue to the cause(s	;)
	othe ithin 2 othe omple	Mec	29b. Signature and title of certifier	and me	A Stated.		29	9c. Licens	e number		29d. Da	te signed (Mo	nth, Day, Year)	
	10		10	I)	U	1/1	11	Λ	52261		भन	eb. 1	, 2006	
	1		30. Name and address of person w	no completed ca										
			Alan R. Seg	all M.I	$\sqrt{299}$	Lamb		on D	r., Si	lver S	rin	g, MD	20902	
		ate	31. Date filed (Month, Day, Year)	8 2006	Registrar's Sign	ature	board							
	Reaist	100	red U	U LUUU	THE STREET AND ADDRESS AND	A11 A	4							

20	•	State of Maryland / Department of Healt 1 - State Registrer Certificate of Dea		ygiene 006	05548
17.15. 186		Decedent's Name (First, Middle, Last)	2. Date of I		3. Time of Death
Physic /Medi		Hsiang H. Hua	Februa	ry 3, 2006	5:45 p ^M
Exami	× .	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loca	tion of Death	4c. County of Deat	th
1 m		14411 Traville Gardens Circle #410 Rockville	Inder 24 Hrs. 8. Date of E	Montgome	
Funeral		5. Social Security Number 1 Months Days Ho	ours Min. (Month, I	9. Sin (9. Sin	thplace (State or Foreign ountry)
Director		074-54-4347 98 fts.	nay 2), 1907 OIII	LIId
ylano how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
e Mar	ctor	Maryland Montgomery Rockville			
ith th	Directo	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?
ath w	rai	14411 Traville Gardens Circle #410 20850 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispani	ic Origin? (Specify Ves or	USA 14. Race - Ame	ancan Indian.
ter de Items	Funeral	Armed Forces? If Yes, specify Cuban, Me	exican, Puerto Rican, etc.)	Black, Whit	e, etc.
urs at	Ď	If Yes, Give 1 ☐ Yes 2 1 No Special No Spec	ecify:	Specify: Asi	ian
72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during	most of working	16b. Kind of Business	
Men.	mple	Elementary/Secondary (0-12) Coffege (1-4or 5+)		Own Home	
ING 21215-UU36 be filled within 72 hours after death with the Maryland hat Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exertine Last te notified at	CO		Mother's Name (First, Midd		
Maryland 21215-UU35 d 2 should be filed within 72 hours at lith and Mental Hygiene. 77 is marked other than "natural", or treumatic event, the Medical Exern	To Be		nknown		
shoul nd Me mark	۳	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and N</i>		nber, City or Town, State,	Zip Code)
Ind 2 alith a alith a 27 is		Wendy H. Chu / Daughter 100 Park Avenue	Suite 288; F	Rockville, M	20850
or He or He country	,	20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
La garante and La gar		4 □Donation 5 □Other (Specify) Parklawn Cemetery		Rockville,	
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Menial Hy importent; if them 27 is marked oth eny injury or other treumatic event page.		21. Signature of Fucural Service Licenseed 22. Name and Address of Simple Tribut 1040 Rockvill	Facility Le Funeral ar Le Pike; Rock	d Cremation cville, MD 20	Center 0852
Ag T		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	ch as cardiac or respirator	y arrest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition a. Pheumonid			Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):	1.		
LXdilliller		Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	iscular di	sease	
ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury			
), execu n and ial-tra	Exa	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
ox 68760, certilicate be executed riding physician and use as the burial-transit	cal	d			
rtitica ng ph	73	IF FEMALE:			
. Box 68 death certitica te attending ph ad for use as th	Physician/Me	23b. Was decedent pregnant 1 Live birth 2 Fetaf death 3 Ectopic pregnancy		23d. Date of de Month	Day Year
. 0 0 0	ysic	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown		-	
F a f a		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I. 23e. D	id tobacco use contribute	to the cause of death?
ds, utres	d by		1	□Yes 2 No 3□F	robably 4 Unknown
Records, he law requires t e has been signe age 2 should be	Completed		24a. W	as an 24b. Were a	autopsy findings available completion of cause of
Rec The lav te has	mo		1 Ye	orformed? death?	
	BeC		Place of Death (Check on		
of V Physic this ce at direc	10 5		Nursing Home 5 R		ecify)
Vision of Vital Attending Physician: r death. sector: After this certifics by the funerat director, it	on:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28c. Injury at Work? Work? M 1 Yes		be how injury occurred	
isio	icat	3 Suicide 6 Could not be 290 Place of Injury. At home farm street factory office		n (Street and Number or F	Rural Route Number,
Division of tor Attending Physister death. Director: After this in by the funeral di	ertification:	4 Homicide determined building, etc. (Specify)		Town, State)	
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinio			
To the within 2 To the complet	Med	29b. Signatyre and title of certifier 29c. License nur	mber	29d. Date signed (Mor	nth, Day, Year)
3		30. Name and address of person who completed cause of death (Ilem 23a), (Type, Print)	71716	rep. 3,	2006'
		Patricia Tomsko Nay 1119 Rockville Pike, G	3-100, Roc	Kville, M.	D 20852
S Regis	tate trar	31. Date filed (Month, Day, Year) FEB 0 8 2006 32 Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. Ne. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** а м 8:00 February 4, 2006 Lillian Macdeline Holford /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince George's Magnolia Garden Lanham | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, April 25, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖰 F 83 Yrs. Virginia 578-18-0561 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State or itema 23a or 28a-f show partment of Health and Mental Hygiene.
ioritant: If item 27 is marked other then "naturel; or itema 23a or 28a-f show injury or other traumatic event, it a Madical Examiner must be notified at 8. 1 ☐ Yes 2 HNo Maryland Prince George's New Carrollton Directo 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20784 USA 5811 Mentana Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Specify: White 1 Never Married 2 Married 1□Yes 2🍎 No Specify: Baltimore, Maryland 21215-0036 3 Midowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Hame Homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Frederick Tremper Lillian Rebecca Loch ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 38452 Ditchling Place, Hamilton, Virginia 20158 Kathryn A. Hardesty/ Granddaughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition February 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If ony injury or Fort Lincoln Cemetery 2006 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Francisand Adeorphias Tuneral Home Inc 500 University Blvd, West, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 Weeks Physician Urosepsis /Medical Due to (or as a consequence of): Examiner 1 Year Pyelonephritis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a curisequerice of): Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐No 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Mitral and Aortic Stenosis, Atrial Fibrillation, 24b. Were autopsy findings available prior to completion of cause of death? Renal Insufficiency 24a. Was an page 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA inis After the funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 🖾 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 28I. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide hours after To the Hospital o within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur D16897 February 7, 2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Phan) William D. Rosson, M.D. 5701 85th Avenue, New Carrollton, MD 20784 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year February 4, 2006 **Physician** 9:00 AM **GUY** THOMAS HOAGT.AND /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 905 Black Spruce Lane Sykesville Carrol1 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Oct. 29,1962 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1(X) M 2□ F 43 217-88-6625 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County ral', or items 23a or 28a-f show Examiner must be notified at Md. Carrol1 Sykesville 1 ☐ Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 905 Black Spruce Lane 21784 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Yes. Give Completed by If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any injury or other traumatic event space. 17. Father's Name (First, Middle, Last) Be John Hoagland Sarah LaScola 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Casey (Sister) 5833 Melville Road Sykesville, Md. 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb. 8, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadow Ridge Mem. Pk. 2006 Elkridge, Md. * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses 10 East Deer Park Dr. Gaithersburg, Md. 20877 Wells 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Congenital Heart Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Levo-Transposition of the Great Vessels Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Wasan has page certificate 2 X No 1☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 ☐ Yes 2 🗓 No 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 24740 6 TH V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE HOSPITAL THOMAS HOPKINS TRAILL TOHNS

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 08

2006

DONEL

32. Registrar's Signature

Christopher M. Harding Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-0819 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar AKG Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 2, **Physician** 2006 11:25 A M Christopher M. Harding /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 5908 Rayburn Drive Temple Hills If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 F 8. Date of Birth (Month, Day, Y 5/18/86 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 219-11-5872 19 Yrs. Director Wash.D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "nature!, or iteme 23a or 28a-f ehor tre Medical Examiner must be notified at P.G. Md. Temple Hills 1 AYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 U.S.A. 3442 Brinkley Road # 402 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 □Yes 2X No It Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Afriçan-Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify. American 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 12th Maintenance Engineer other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I Crystal L. Harding Robert Leftwich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3442 Brinkley Rd. #402, Temple Hills, Md. 20748 Pages 1 and 2 ment of Health a ant: If item 27 is Crystal L. Harding/Mother altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State PBurial 2 ☐ Cremation 3 ☐ Removal from State ō artment ortant: injury 2/11/06 Ft. Lincoln Cem. Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) Departimports any injustical 21. Signature of Funeral Service Licensee 22. Name and Address of Facility & Sons Co., Inc. any nau 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final Immediate Causo (, disease or condition resulting in death) SHOTGUN **Physician** WOUND OF /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Examine The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. been signed by the s 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy 24b. Were autopsy tindings available prior to completion of cause of teall ? 1 Yes 2 ☐ No 2 🗆 No After this certification, funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence State (Specificat Scene Certification: To XXYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Yea 27. Manner of Death 28b. Time of Injury FOUND 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 De SUBJECT WASSHOT 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 2 Accident Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5908 AYBVEN DRIVE, TEMPERING 3 ☐ Suicide filled in by Homicide ō To the Hospital within 24 hours a To the Funeral completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) February 3, 2006 O.C.M.E. Cause of death (Item 23a) (Type, Print)

On R A \ 111 Penn Street, Baltimore, Maryland person who comple 21201 2. Registrar's Signature 31. Date tiled (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #23 per.PHYS 2/10/06 PGCH elm 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** January 23 2006 7:55am Elmer Joseph Hill /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Prince George Fort Washington Medical Center Fort Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1⊠ M 2□ F Yrs. June 23, 1918 579-14-5076 Maryland Director Usual Residence of Decedent be filed within 72 hours after deeth with the Marylend 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28e-f show traumetic event, the Modical Examiner must be notified at 1 ☑ Yes 2 ☐ No Funeral Director Maryland Prince George Fort Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12021 Livingston Road 20744 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black Be Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pegas 1 and 2 should be filed within bepertment of Health and Mentel Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic averages. Elementary/Secondary (0-12) College (1-4or 5+) Freight Drivers Union 12 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Cornelius Hill Amy Beatrice Bouroughs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marietta Broadway/Daughter 1 Cooperative Dr. #13, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Buria! 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 1/28/06 Brentwood, MD 4 ☐ Donation 3 ☐ Other (Specify) 21. Signature of Fur eral Service Life 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 notications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death or compl List only or **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 116 Examiner Due to (or as a consequence of): Physician/Medical Examiner Deme into or Attending Physician: The law raquiras that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, that initiated events Due to (or as a consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dystanction 1 ☐ Yes 2 ☐ No 3 ☐ Probably Donknown ģ page 2 should be 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Be Completed completion of cause of death? 1 Vos Stallo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending s after deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral Di completaty filled in 29a. Certifier (Check only one) end manner stated. 29d. Date signed (Month, Dey, Yeer) 29b. Signature and title of certifier 29c. License number 1) 42955

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person

11701

Calan

who completed

32 Registrar's Signature

ause of death (Item 23e) (Type, Print)

Rel.

t. Washington

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar <u>Amend#2.PerPhys.PCC 2-14-06 cr</u> Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month FEB Day **Physician** 5:50 PM M ALBERT 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 2-28-08 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 □ F Months 97 SOUTH CAROLINA Director 243-07-4380 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h. County in than "natural", or items 23a or 28a-f show the Medical Example of costs be notified at MD MONTGOMERY

10e. Street and Number

505 SPRINGVALE ROAD #A109

11. Marital Status

1 Never Married 2 Married

1 Yes, Give XX Yes 2 No SILVER SPRING 10g. Citizen of What Country? 10f. Zip Code 20910 S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene important: if Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Feminance. 1 Tes 2000 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BETHLEHEM STEEL CO. 8TH GRADE MACHAN1C 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ROBERT HIGGINS ELLA HILL ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 75 SHERIDAN ST., N. E. WASH . , DC 20011 20c. Location - City or Town, State ELLA H. HALL Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State LINCOLN MEMO. CEMETERY 2-10-06 SUITLAND, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility PINCKNEY-SPANGLER FUNERAL HOME 21. Signature of Funeral Service Licensee 524 - 8TH ST., N. E. WASH., DC 20002 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on early tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Friysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last anding physician an use as the burial-tr Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical use as IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten for u Day Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown sate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed certificate 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred te-medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 No 2 1 🗌 Yəs 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 24 hours after of Funeral Diract 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Chack only one) and manner stated. within 2 To the 29c. License number 29d. Date signed (29b. Signature and title

Registrar

Name and address of perso

completed

			For State Registrar	State o	of Maryland / Dep. Ce	artment of He rtificate of D		, ,	iene .g. 12.006	05554
	Physic		Decedent's Name (First, Middle ROBERT LEE HE			,		2. Date of Deat Month	th Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution		m <i>ber)</i>	4b. City, Town, or	ocation of Death	FEBRUAR	Y 08, 2006 4c. County of Dear	
		2 ⁽²⁾	PRINCE GEORGES				VERLY		PRINCE	GEORGES
繁	Funeral Director		5. Social Security Number 579 50 0991	6. Sex XX M 2□F	7. Age (In yrs. last birthday) 66 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, DEC • 29	9. Bin CC WAS	hplace (State or Foreign unity) HINGTON, DC
	yland Now		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocalion				10d. Inside City Limits
	a-f sh	ctor	MD PRINC	E GEORGES	UPPER MA	RLBORO				XXYes 2 □ No
	vith th	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	•
	eath v	Funeral	14000 NEW ACAD				0774	noity Vos or No	UNITED ST	
39	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental hygiene. It has a second second that the marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Madical Experiment or the partition at	by Fun	1 Never Married XXMarriad 3 Widowed 4 Divorced	Armed Fo	2 No 1958-	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2\(\text{X}\)No	Specify:	Rican, etc.)	Black, Whit	e, etc.
2-0	72 hou	eted	15. Deceden		16a. Dece	dent's Usual Occupate kind of work done du	ion	ina	16b. Kind of Business/	Industry
121	within no.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) life.	DO NOT use retired)	Ū			
9	Hygie Hygie other i	င္ပ	12TH 17. Father's Name (First, Middle,	Last)	RADIO	LOGIC TEC	INOLOGIST 18. Mother's Name			RGES HOSPITA
<u>Ilan</u>	uld be Jental rked o	To Be	JAMES HEWINS,	SR.			ALBERTA	COOK		
Maryland 21215-0036	2 should and Men is marks aumatic		19a. Informant's Name/Relations						City or Town, State, 2	
	of Health of Health litem 27		THOMASINE J. H 20a. Method of Disposition	EWINS / W					R MARLBORO 20c. Location - City or	
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	Vithin Fo tha	Mec	29b. Signature and title of certifier	A.	O states.	29c. License	number	29	d. Date signed (Monti	n, Day, Year)
			> K. Mu	had To	SV-	000	52865		February	08, 2006
M	-7		30. Name and address of person of MICHAEL FIGRO		e of death (Item 23a) (Type, PITAL DRIVE C		TD.			
27%	Sta	te	31. Date filed (Month, Day, Year)		egister's Signature	neverly, M	ш			
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			1 - For State Registrar	State of Mar	yland				ealth a			giene	HIIIh	05	55	55
	Physici	an	Decedent's Name (First, Middle, Last, Dorris S.	Howser						1	2. Date of Dea Month Februar		y 200ce		ne of De	
	/Medio		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o				. County of De			P "
	LAGIIII		15320 Pine Orcha	rd Drive,	#3C		Si	lver	Spri	ing			Montgo			
	- Funeral Director		5. Social Security Number 6. Security Number 6. Security Number 6. Security Number 1	7. Age ((In yrs. Ia 85	st birthday) Yrs.	Months	1 Year Days	Hours	Min.	8. Date of Birt (Month, Day Pril 2:	h K Year) 3 . I	9. B	irthplace (Si Country) w Hamp	ate or F	Foreign
	D		Usual Residence of Decedent]		P***		110	w Hang	75111	10
	ehow	7	10a. State 10b. County Maryland Montgome			Town or Lo		a						10d. Insi	de City I	
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23e or 28e-f ehow eny Injury or other traumatic event, If a Medical Examination at the inclining at once.	y Funeral Director	1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2X No If Yes, Give			Was Deced f Yes, spec		spanic Orig n, Mexican Specify:		cify Yes or No- lican, etc.)		14. Race - An Black, Wh Specify: Wh	nite, etc.	ın,	
21215-0036	tural'	ed by	3 ☐ Widowed 4 🖸 Divorced 15. Decedent's Edu	Year or Dates:		16a. Dece	lent's Usua	al Occupa				16b K	ind of Busines			-
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Maryland	ould be fil Mental H arked oth atic even	To Be	17. Father's Name (First, Middle, Last) Cecil A. Stiles								(First, Middle, Stiles	Maiden	Sumame)			
Mar	d 2 shi th and th and 7 Is m traum		19a. Informant's Name/Relationship (Ty.) Marcus S. Howser/S				•	•			Route Numbe 35, La					
6	t Heal		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Nan	ne of	-)	Da	ite		ocation - City o		te	
<u><u>E</u></u>	Page nant: II		1 ☐ Burial 2X☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		opolita				bruary 200		Alex	andria	, Virg	jini	a
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Divisio	or Attend after death Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At hom (Specify)	ne, farm, str	M eet, factory		/es 2□N		3f. Location (S City or Tow			Rural Route	Numbe	Γ,
	Hospita 24 hours Funeral	Medicai C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examir	ician: To the best of refer: On the basis of each and manner state	kaminatio	ledge, death on and/or inv	occurred estigation,	at the time	e, date and inion, deat	d place, an	nd due to the o	ause(s)	and manner a d place, and du	as stated. Je to the cau	ıse(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	10-11	1/1		290	License					te signed (Mor			
	10(3)		• // //	1 1100	U	-		D38	457		F	ebr	uary 8	, 2006)	
			30. Name and address of person who co Nakul Goyal, M.D.	mpleted cause of deat 3801 In	th (Item 2 tern	3a)(Type, ation	al Dr	ive,	#211	, Si	lver Sp	orin	g, MD	20906		
4	Sta Registr		31. Date filed (Month, Day, Year) FFR 0 9 2006	32. Registrar's	Signatu	re Acces	es es									

DHMH 17 Rev 1/2001

			For State of M	aryland / Depa <i>Cer</i>	artment of He tificate of L			iere	6 05556		
			Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h	3. Time of Death		
	Physicia /Medic		Sarah Lolita HENDRICKS				Februar	Day v 12 20	0 4 1 H. M.		
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County			
			126 Ray Street		Hagerst				ington		
	Funeral		1 M 27 F	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	 Date of Birth (Month, Day, 	Year)	Birthplace (State or Foreign Country)		
	Director		220-10-3140 Usual Residence of Decedent	88 Yrs.			April 6	1917_	Maryland		
	tand ow		10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits		
	Many Fish	ţō	Maryland Washington	Hager	stown				1 ∀es 2 □ No		
	r 28e	Directo	10e. Street and Number		10f. Zip Code		1:	0g. Citizen of V	Vhat Country?		
	th wil		126 Ray Street			1740		USA			
	r dea	Funeral	11. Marital Status 12. Was Decedent Armed Forces	1	Was Decedent of His f Yes, specify Cubai	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, ck, White, etc.		
36	within 72 hours after death with the Maryland ene. Than "heturel", or Items 23e or 28e-f show he Medical Examinar must be nutitied at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ ☐ If Yes, Give Year or Dates:	No .	1 ☐ Yes 2🌠 No	Specify:		Specify	White		
Maryland 21215-0036	turel	edb	15. Decedent's Education	16a. Deced	dent's Usual Occupa	ition		16b. Kind of Bu	usiness/Industry		
77	n "ne" ne	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	life. L	kind of work done a DO NOT use retired,		ing				
7	d with	E	8 0		iter			Aircraf			
g	al Hy al Oth d oth	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, I	Maiden Sumam	ie)		
yla	Ment Ment Ment Marke Marke	P.	William Edward Sharer			Mary V	irginia	Shipley			
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e,	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Menhal Hygiene. If item 27 is marked other than "neturel; or Items 23e or 28e-1 show or other traumatic event, the Medical Examinating restricted at		Beverly McElroy - Daughter 20a. Method of Disposition	20b. Place of Dispo	Ray Stree sition (Name of		cstown,		1d 21/40 City or Town, State		
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	nit. P artme orteni injury		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 1 Funeral Service Licensee	Greenlawn	Mem. Par Name and Addres		706 Iinnich		Home Home		
Ba	Pen Pen Suny		Jan M/Mu	me 4	15 E. Wil				Maryland 21740		
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Re	he lav	ш	CORDINATION IN THE	C1-7 151	- (1136		autops perfor	sy med?	prior to completion of cause of death? 1 🗆 Yes 💮 No		
ta	In: T tificate lor, pa	Be Co	25. Was case referred to medical			26. Place of Dea			TI THIS X INO		
\leq	ysich is cer direct	0	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpat	ent 2 ER/Outpatier	nt 3 DOA Othe	er: 4 🗆 Nursing H	ome Resid	ence 6 Oth	ner (Specify)		
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Ž	l or Att after d Direct J in by	Certification;	determined 288, Flace of II	jury - At home, farm, str tc. <i>(Specify)</i>	reet, factory, office		City or Tow	n, State)	ber or Rural Route Number,		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier Certifying Physician: To the bes	of my knowledge deat	h occurred at the tim	ne date and place	and due to the c	ause(s) and ma	anner as stated.		
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	To the To the To the Complex c	₹	29b. Signature and the of certifier		29c. License		2	29d. Date signe	ed (Month, Day, Year)		
			penah	MD	50	8181		02/1	4/2006		
sН	-10		30. Name and address of person who completed cause of	death (Item 23a) (Type,	Print)	7 Ave	Hager	Ston	n MD 21740		
110	Sta	ite	31. Date filed (Month, Day, Year) 5 2006 32. Regis	rar's Signature	1.1.	, ,,	7	- 10 -			
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		1 - For State Registrar			rtificate of		, ,	ZUU6	U555/
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/Med Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death	rebruary	4c. County of De	
67	P	107 Patunxet Mobilian Social Security Number 6. S		last hirthday)	Lothia		8. Date of Birth	Anne Aru	
Funeral Director			□M 3/3/F 47	Yrs.	Months Days		Nov 18,	1958 Ge	irthplace (State or Foreign Country) rmany
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
ie Mary 86-f eh	ctor	Maryland Anne Ar	undel I	Lothiar					1 □ Yes 2 ₩ No
with th	Funeral Director	10e. Street and Number 107 Patuxent Mob	oile Est		10f. Zip Code)711		ig. Citizen of What (Germany	Country?
r death	Inera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spe ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28s-1 show any injury or other traumatic event, the Medical Exprising must be notified at ponce.	by Fu	1 ☐ Never Married ※※ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 Mo If Yes, Give Year or Dates:	ĺ	1 ☐ Yes 2 ☐ No			Specify:	White
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Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or myortant: if them 27 is marked other than "natural", or in highly or other traumatic event, the Medical Examples.			her)						t Virginia
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/Medical		disease or condition resulting in death)	Due to (or as a consec						
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risio Attendi death. ctor: A	ficati	2 Accident investigation 3 Suicide 6 Could not b		ome, farm, st		Yes 2 No	28f. Location (Str	eet and Number or	Rural Route Number,
Div Itel or / Its after af Dire	Certification:	4 Homicide	28e. Place of Injury - At h building, etc. (Speci	fy)			City or Town	, State)	
Division of To the Hospitel or Attanding Physwithin 24 hours after death. To the Funeral Director: Attar this completely filled in by the funeral di	Medicai		nysician: To the best of my kin niner: On the basis of examina and manner stated.						
To the within To the comple	Me	29b. Signature and attle of certifier	0 0			nse number	1	d. Date signed (Mo	
		1 Clarko	Kein!	m ((3e) /T =		CME	F€	bruary, 1	.6, 2006
10		30. Name and address of person who	completed are of death (Itel	п ∠за) (Туре,		enn Street	Baltin	ore, Mary	land 21201
Si Regis	tate trar	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	soli .				
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HOUGHTON, Catherine C.

		1 = For State Registrar	State of Maryl		rtificate of			Reg. No.	UD	
Dharai	ion	Decedent's Name (First, Middle, La.	st)			-	2. Date of De Month	ath Day	Year	3. Time of Death
Physic /Medi		Catherine C	hrismore I	Houghtor	1		Februar		2006	9:35 P
Exami		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death			ounty of Deatl	
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Funeral Director		5. Social Security Number 6. S 224–1.0–9820	_ 52_	yrs. last birthday) 95 Yrs.	Months Days		July 1	Year 9	Co	hplace (State or Forei untry) Q ini a
		Usual Residence of Decedent					Journ I	-,	TO VIL	gilla
yland		10a. State 10b. County	10c.	. City, Town or L	ocation					10d. Inside City Limit
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or 26	Dire	10e. Street and Number	1.0		10f. Zip Code	2		_	en of What Co	untry?
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ltems	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 XNo	in U.S. 13.		Hispanic Origin? (Sp an, Mexican, Puerto	o Rican, etc.)	.	Black, White	
permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28e-f show any injury or other treumetic event, the Medical Expiring must be a cultified at any injury or other treumetic event, the Medical Expiring must be a cultified at any injury or other treumetic event.	by Funeral Director	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2XNo	Specify:		S	Specify: What	ite
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thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of world)	wing .	01		
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12 should be filed within hand Mental Hygiene. 7 is marked other then "Ireumatic event, the Men	Be	17. Father's Name (First, Middle, Last,					inkfield		umame)	
hould d Mei mark martic	To	Harry Franklin (19h Mail	ling Address (Street	t and Number or Ru			Town, State, 2	Zip Code)
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1 en Heal tem 2		20a. Method of Disposition		b. Place of Disp	osition (Name of ematory or other pla	1	Date		ation - City or	
ages ant of nt: If i		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif			ron Cemet	·	5/06	Wind	chester	- VA
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		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the							Approximate
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Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vaar **Physician** 1005 M February 2006 Edna Pauline Hixon /Medical 4b City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Washington County Hospital If Under 1 Year If Under Months Days Hours 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** 1 ☐ M 27 F 86 Yrs. March 30,1919 WV Director 213-24-9199 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City. Town or Location 10a. State show rthan "netural", or iteme 23a or 28a-1 shov the Medical Examiner must be multiled at 1 ☐ Yes 2X No Directo Warfordsburg ·PA Fulton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 17267 1731 Lehman Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County Government permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Important: If item 27 ie marked other It sny injury or other treumstic avent, ILLA DDCE. Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Weese Espy Mann 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1731 Lehman Road Warfordsburg, PA 17267 Philip W. Hixon/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Buck Valley Christian 02/15/06 Warfordsburg, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only onle cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cere provasca lay **Physician** /Medical Due to (or as a consequence of): Examiner entille Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Conor Due to (or as a consequence of) Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month Day signed by the atte 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Nhnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a Was an 2 No 1 Yes 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25€No 1 Mnpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 19 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2/13/8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 26 Opal 32. Resistrar's Signature 31. Date filed (Month, Day, Year)

State

Registrar

2006

 $\mathcal{L}_{\mathcal{U}}\mathcal{M}e/\mathcal{D}$. $\mathcal{H}emsley$ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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		CIVISTA MEDICAL CE 5. Social Security Number 6. Sex	VTER	ast birthday)	LAPLATA If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	CHARLES	rtholace (State or Foreign
Funeral Director			M 2□F 43	Yrs.	Months Days	Hours Min.	(Month, Day, JAN - 21		rthplace (State or Foreign ountry)
or death with the Maryland items 23e or 28a-f show refinant be the lifted at	tor	10a. State 10b. County MARYLAND CHARLES		PLAT					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
or 288	Funeral Director	10e. Street and Number			10f. Zip Code	-	10	g. Citizen of What C	
eath w	eral		OAD 2. Was Decedent Ever in U.	S 13	20646		acity Vas or No.	U.S.A	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or items 23e or 28a-f show aumatic event, Item Medical Exact in sermost Le rediffed at	by	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2☐No	Specify:	Rican, etc.)	Black, Wh	
ithin 72 ho 18. 18n "natur 18e Jicul	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation co <i>mpleted)</i> College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of work	ing 1	6b. Kind of Business	s/Industry
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uld be Vental irked o	To Be	LAWRENCE DE VINC	ENT MUSCHE	TTE			HEMSLI		
and 2 sho balth and I n 27 Is ma		19a. Informant's Name/Relationship (Type MARY C. HEMSLEY-			-			City or Town, State,	
Pages 1 and the pages 1 and th		20a. Method of Disposition X Burial 2 □ Cremation 3 □ Re		lace of Dispo emetery, crer	sition (Name of matory or other place	9)	Date 2	0c. Location - City o	r Town, State
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Importent: If item 27 Is marked other then "naturany injury or other traumatic event, Item Medical ODCS.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Emeral Service Licenses	SACREI MOO479	22 R	RT CH. C 2. Name and Addres: AYMOND F	s of Facility UNERAL	SERVICE	E, P.A.	MARYLAND
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Physician		Immediate Cause (Final disease or condition	Ainte he	patiti	9				Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):	tu				
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ		1				
be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	Jence of):		_			
0 5 0	calE	d.							
ertificat ing phy e as th	****	IF FEMALE:							
The law requires that the death certificate tate has been signed by the attending physic page 2 should be detached for use as the tate.	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
w requires that been signed b should be deta	by	Part II. Other significant conditions conti	ibuting to death but not resu	ulting in the u	nderlying cause give	n in Part I.	23e. Did toba	1	to the cause of death?
sicien: The law re certilicate has bee lirector, page 2 sho	Completed						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
icien: certific ector,	Be	25. Was case referred to medical examiner?	spital:		Othe		(Check only one	-	
Phys ar this eral dir	n: To	1 ☐ Yes 2 🗙 No Pro	28a. Date of Injury	ER/Outpatien 28b. Time of	28c. Injury	at Nursing Ho	me 5 🗌 Resider 28d. Describe hov	ice 6 Other (Spi v injury occurred	ecify)
anding sath. or: Afte	ation	1 Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury	M 1 □ Y	? ′es 2 □ No			
after de Directe	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director, to	Medical C	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	cian: To the best of my known: On the basis of examinat and manner stated.	wledge, death ion and/or in	n occurred at the time restigation, in my op	e, date and place, inion, death occurr	and due to the cau ed at the time, dat	use(s) and manner a e and place, and du	is stated. e to the cause(s)
To the comp	W	29b. Signature and title of continer	MD		29c. License			d. Date signed (Mon 2/15/06	ith, Day, Year)
3		30. Name and address of person who com JARIWALA MANISHA J				WALDORF	MD 2060	72	
Sta Registr		31. Date filed (Month, Day, Year) FEB 2 4 2006				"TILDORT	2000	<i>-</i>	
MH 17 Boy 1/20			1	-					

		1	State of Maryland / I		tment of He			ene 2.006	05561
			Registrer 1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		Betty T. Johnson				Februa	$r_y^{Day} 5, 2$	006 11:00A ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)		b. City, Town, or			4c. County of	
			3444 Newport Avenue		Annapol	If Under 24 Hrs.	8. Date of Birth		Arundel
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M ★□ 7. Age (In yrs. last bit 1 ☐ M ★□ 6.9		Months Days	Hours Min.	Month, Day, Nov. 20	,1936	n. Birthplace (State or Foreign Country) Mississippi
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	wn or Loca	tion				10d. Inside City Limits
	Maryla f sho	tor	MD Anne Arundel Anna						1 ∰Yes 2 No
	h the	irec	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wh	at Country?
	23a c	ralD	3444 Newport Avenue		21403			USA	A in a la dia a
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ira Modical Exactified. Mail to Indiffed at Once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		••	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes of No- Rican, etc.)	Black,	American Indian, White, etc. Black
2-00	72 hou	Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give kii	nt's Usual Occupa nd of work done d	urina most of work	ing 1	16b. Kind of Busi	ness/Industry
121	12 should be filed within and Mental Hygiene. 7 Is marked other than "raumatic event, It e Mes	dmo	Elementary/Secondary (0-12) College (1-4or 5+)		otomist			Hospita	al
d 2	illed Hygir other	Be Cc	17. Father's Name (First, Middle, Last)				e (First, Middle, M		
ylan	Menta Menta arkad atic ev	To B	Cyrus Taylor				ine Fau	<u>\</u>	
Maryland 21215-0036	and 2 sho ealth and m 27 Is m	A STATE OF				Ave.,			
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 iry or other tra	877	20a. Method of Disposition X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	of Disposit Ngto Onal	tion (Name of atory or other place Cemete	ery 2/13			ity or Town, State
Balti	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee Notice & House	81 A1	Name and Addres 4 Frank exandri	s of Facility Great In Sti	ene Fu 2314	neral	Home, INC
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.					est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	NCM	, F,S	ROSI			Years
	/Medical Examiner		Due to (or as a consequence	e of):	/				/
	p #	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	e of):					
	xecute and al-trans	Examiner	at initiated events sulting in death) Last Due to (or as a consequence of):						
8760	cate be executed physician and the burial-transit	dical E	d						
9	leath certifica attending ph I for use as th	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy					23d. Date	of delivery
О. Вох	the death by the atter	Physician/Me	230. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)			Mont	
rds, P.	quires that the de n signed by the a uld be detached f		Part II. Other significant conditions contributing to death but not resulting	g in the und	derlying cause give	en in Part I.	23e. Did tob		bute to the cause of death? B Probably 4 Unknown
Records,	The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by					24a. Was a autops perform	ned? pr	ere autopsy findings available for to completion of cause of eath?
ita	(0	Be C	25. Was case referred to medical examiner?		T-air		th Check onl on	е	
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient	3□ DOA Oth	4 Nuising n	ome 5 Reside		
ouo	ding After fune	tion:	27. Manner of Defith 28a. Date of Injury (Month, Day Year) 28b 27. Accident investigation 28b.	o. Time of Injury	28c. Injun Worl	yat k? Yes 2 □ No	Zod. Dosonos no	ow injury occurre	
Division of Vital	or Attanding frer death. Director: After in by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (St City or Town		r or Rural Route Number,
Ω	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inve	occurred at the tin	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and mar ate and place, a	ner as stated. nd due to the cause(s)
	To tha within 2 To the comple	Med	29b. Signature and the of certifier		29c. Licens	e number 35 4 9 4	2	9d. Date signed	(Month, Day, Year) 2086
	(14)		30. Name and address of person who campleted cause of death (Item 23a	a) (Type, F	Pripro) 1 r	Air	Anna	0001	Mb
K_			at Date Head (Marsh Day York)	600	171 agd	7	- / / - 000	1012	111/
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB Q 8 2006	med	5				

			For State Registrar	State of Maryland		artment of F			Reg No.)	6 (556	2
	Dhualai		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath Day	Year	3. Time of 8:40	Death
	Physici /Medic		David	Vernon		Jenkins		Februa		006	0.40	A M
	Examin		4a. Facility Name (If not institution, giv	re street and number)		4b. City, Town, o	r Location of Dea	th	4c. Coun	y of Death		
		¥. 4.7	Bayside Care Cen	iter		Lexingto				lary's		
ŧ	Funeral	128.8	Social Security Number 6. S	MIM 2DE		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da	y, Year)	9. Birthp	lace (State o ntry)	r Foreign
	Director		24/-32-4115	80	Yrs.			December	1,1925	South	Caroli	na
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City	. Town or Lo	ocation				1	0d. Inside Cit	ty Limits
	sho	ŏ				1					1 🗌 Yes	2 X No
	the N	Director	Maryland St. Mary	y's Lo	vevil	Le 10f. Zip Code			10g. Citizen of	What Cour	ntry?	
	a or	ā		0 1							,	
	s 23	Funerai	26376 Loveville 1	KOad 12. Was Decedent Ever in U.S	3 13	20656	lispanic Origin? (Specify Yes or No	USA	ice - Americ	an Indian.	
_	iter d	un.	11. Marital Status 1 ☐ Never Married 2X Married	Armed Forces?		Was Decedent of H If Yes, specify Cuba	an, Mexican, Pue	rto Rican, etc.)	Bi	ack, White,		
5	urs af	by F	3 Widowed 4 Divorced	1 MYes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2XXNo	Specify:		Spec	ity: B1a	.ck	
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than 'natural', or Items 23a or 28a-f show ont. The Madical Examinat must be pudified at		15. Decedent's E	ducation		dent's Usual Occup			16b. Kind of	Business/In	dustry	
2	nin 7.	Completed	(Specify only highest grant Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	life.	kind of work done DO NOT use retired	d) most of wo	orking				
7	T the	E	8	Oollege (1-401 5+)	Eng	ineer			U.S. Gov	ernmen	t	
<u> </u>		0	17. Father's Name (First, Middle, Last)			18. Mother's Na	ame (First, Middle,	, Maiden Suma	ime)		
Maryland	should be nd Mental marked c	To B	David Jenkins				Rose Le	ee Posles	зу			
a	sma sma		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or P	Rural Route Numb	er, City or Tow	n, State, Zip	Code)	
	and 2 palth 27 i		David Russell Jenkins	/ Son	26376	Loveville H	Road, Love	ville, Mar	y1and 206	556		
ıtımore,	es 1 and 2 should b of Health and Ment if Item 27 is marked ir other traumatic e		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	75 CE	metery, cre	osition (Name of matory or other place	ce)	Date	20c. Location	- City or To	own, State	
Ĕ	nait. Pages sartment of l cortant: If its injury or o		4 Donation 5 Other (Special		Hope H Cemete		02/1	11/2006	Hod es, S	South C	arolina	
galt	permit. Departminitude importa		21. Signature of Funeral Service Lice	nsee	2 Me	2. Name and Addre	ss of Facility	peral Home	ъΛ			
מ	8 2 E E S		To echael Y	Tardere 7.		0. Box 270)		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused he death	. Do not en	ter the mode of dyir	ng, such as cardia	ac or respiratory a	rrest,		Approximat Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	Xs	111	12				155	Onset and I	Death **
	/Medical		resulting in death)	a Due to (or as a conseq	ence of):						1	
	Examiner		Sequentially list conditions	b Pm	Qu	mone	a				VBS	_
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Dua to (chas a consequ	ence of):							
	nd nd trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
Ď,	be executed sicien and burial-transit	Ē	resulting in death) Last Due to (or as a consequence of):									
3/60	ate be ex hysicien the buria	lical		d								
Õ	the death certificate y the attending phys Iched for use as the	Physician/Med	IF FEMALE:									
X Q Q	ath c	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar	death 3[Ectopic pregnancy	,			ate of deliv fonth		Year
_	the a	/sic	1 Yes 2 No	4☐Pregnant at time of de 9☐ Unknown	ath 5	Other (specify)						
J.	w requires that the de been signed by the should be detached		Part II. Other significant conditions	contributing to death but not resu	itting in the i	ınderlyina cause au	ren in Part I	23e. Did t	obacco use co	ntribute to t	he cause of o	death?
Š,	The law requires that ate has been signed b page 2 should be deta	þ	Tattii. Othor significant conditions	A	1	100	or are are a		Yes 2 No			
cords	requ	Completed	T. 1	D 1-		11/1/1/1			1			
ဥ	e 2 s	npi	- JASON	Jean En	1/	(ZMMB)		24a. Was	psy prmed?	prior to co death?	opsy findings impletion of c	available ause of
<u>=</u>		Ö							2 No	1 Yes	2€ No	
VItal	Physicien: The law this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Ott		eath (Check only	one)			
o	this ald	ြ	1 Yes 2 No	1 Inpatient 2	ER/Outpatie	IN 3 DOA		Home 5 Resi			fy)	
	fing Afte fune	lo U	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	rk? Yes 2 □No	28d. Describe	now injury occ	ulled		
<u>ड</u>	or Attending ifter death. Director: After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	De One Diese of Injury At he	me farm et			28f Location (Street and Nur	nher or Rur	al Route Num	her
DIVISION	of or Attency after death Director:	Certification:	4 Homicide determined	building, etc. (Specify)	reet, ractory, omos			wn, State)			,
	To the Hospitel of within 24 hours at To the Funerel D completely filled it		29a. Certifier 1 Certifying P	hysician: To the best of my know	wledge, dea	th occurred at the ti	me, date and place	ce, and due to the	cause(s) and	nanner as	stated.	
	Hos 24 h Fur etely	Medical		miner: On the basis of examinat and manner stated.								>)
	To the within 2 To the comple	₩.	29b. Signature and title of certifier	011	1.1	29c. Licens	se number		29d. Date sign	ned (Month.	Day, Year)	
ŧ) amapy	Photos	111	DI	06419	9	2-1	-6	12	
	3		30. Name and address of person who	completed cause of death (Item	23a) (Type	. Print)			0 7		<u> </u>	
			James P. Jarboe, M.D.				d. Marvl <i>a</i> n	d 20636				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar' signa	ture	-						
	Regist		FEB	0 6 2006	زار رده	Sport.						

			For State Registrar	State of Maryland /		tment of H		-	giene Reg. Ne. () {)6 (55	63
	* *	\$	Decedent's Name (First, Middle, Last)					2. Date of Dea	ith		3. Time of	Death
	Physicia		Debra Ann	Johnson				Februar	Day 2 3 2	Year 2006	4:45	a.m.
	/Medic Examin	100	4a. Facility Name (If not institution, give str		4	4b. City, Town, or	r Location of Deat			ty of Death	10 13	CL V III V
	LAAIIIII		30515 Vinessa	Court		Char1	Lotte Hai	11	St	. Marv	's	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b			If Under 24 Hrs Hours Min	8. Date of Birt	h		ce (State o	r Foreign
	Director		217-68-5875	w 2 X F 49	Yrs.	Wioritis Days	710013	May 16		Mary1		
	p ,	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	num or Loca	ation				10	d. Inside C	ity Limits
	anyla	-									1 🗌 Yes	5
	Ba-f	Director	Maryland St. Ma	ry's	Cha	rlotte I	Hall		10g. Citizen o	f What Count	w?	
	with ti	ă	10e. Street and Number									
	ath v	rai	30515 Vinessa	Court 2. Was Decedent Ever in U.S.	13 \\		0622	Specify Yes or No		State		
	er de Item	Funerai	11. Marital Status 11. Never Married 2. Married	Armed Forces?	If Y	Yes, specify Cuba	an, Mexican, Pue	rto Rican, etc.)	В	lack, White, e	tc.	
36	rs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1[Yes 2 No	Specify:		Spec	ity: Whit	e	
21215-0036	72 hours after death with the Maryland naturel', or iteme 23e or 28e-f show deal Exam er must be notified at		15. Decedent's Educa		Sa. Decede	nt's Usual Occup	pation		16b. Kind of	Business/Indi	ustry	
15	n n	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life. DO	nd of work done O NOT use retired	during most of wo d)	orking				
212	d with	Completed	10	College (1 401 01)	Hom	emaker_			Owr	1 Home		
פַ	othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	ime (First, Middle,	Maiden Sum	ame)		
<u>a</u>	Aenta Aenta rked tic e	ToE	Paul Benjamin					Mabel Vi				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene if the Marylan Item 27 is marked other then "natural", or itema 28a or 28a-f show other traumatic event, if a Marylan Exam or must be notified at		19a. Informant's Name/Relationship (Typ	e, Print) 19	9b. Mailing	Address (Street	and Number or F	Rural Route Numbe	er, City or Tou	m, State, Zip	Code)	
Σ	and Salth		James Edward Johr				a Court,					
Sre	of He		20a. Method of Disposition 1	ceme	of Disposi etery, crema	tion (Name of atory or other pla	ce)	Date	20c. Locatio	n - City or Tov	wn, State	
Ĕ	Pagnent ant: I		4 □ Donation 5 □ Other (Specify)		Of P	eace Cer	m. 2-7	-2006	Helen,	, Maryl	Land	
altimore,	permit. Pages 1 Department of H Important: If ite eny injury or ott		21. Signature of Funeral Service License			Name and Addre		unorol U	omo D	۸		
Ω	88 5 8		Edward N. Brinsfiel		30	195 Thr	ee Notch	uneral H Rd., Ch	arlotte	Hall,		
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Decause on each line.	o not enter	the mode of dyin	ng, such as cardia	ac or respiratory a	rrest,		Approxima Interval Be Onset and	tween
100	Physician		Immediate Cause (Final disease or condition	Paurent	70,	Cane	01				Oliset and	Death
Agin Jam	/Medical		resulting in death)	Due to (or as a consequence	ce of):							
157.	Examiner		Sequentially list conditions.									
	p :	iner	Sequentially list conditions, b. it any, loading to immediate cause. Enter Underlying	Due to (or as a consequence	ce of):							
	ecute ind trans	Examin	Cause (Disease or injury that initiated events c. resulting in death) Last	D to /o	1):							
ő,	te be executed ysician and e burial-transit	Ä	resulting in deathly Last	Due to (or as a consequence	ce or):							
8760,	ate b	edicai	d							_		
9	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Mec	IF FEMALE:	sc. If yes, outcome of pregnancy					024	Date of dollers		
Вох	attenc for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal dea	ath 3 ⊡€	Ectopic pregnanc Other (specify)	у			Date of delive Month	Day	Year
<u>o</u> .	at the de by the a tached t	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	1 30	Other (specify) _			1			
<u>a</u> .	hat the do by detac		Part II. Other significant conditions con-	tributing to death but not resulting	a in the un	derlying cause gr	ven in Part I.	23e. Did	obacco use c	ontribute to th	e cause of	death?
ds,	ires that signed t	d						113	Yes 2 □ No	3 Prob	ably 4	Unknown
0.0	w requir been si should	Completed						24a. Was	an 24	b. Were autor	nsy findings	s available
3ec	elaw has l	jdu						auto		prior to cor death?	npletion of	cause of
=								1 ☐ Yes	2 No	1 🗌 Yes	2 No	
Vital Records,	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		Ot	har	eath (Check only		21 (2 (
ot	Phys this ral dii	To	1 Yes 2 No	1 Inpatient 2 EHV	Outpatient b. Time of	3L DOA	4 110131119	28d. Describe	how injury oc		()	
	ding After fune	lo E	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28t	Injury	28c. Inju Wo	ork?]Yes 2∐No		, ,			
Division	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At home	, farm, stre			28f. Location	Street and Nu	ımber or Rura	l Route Nu	mber,
<u>S</u>	i Si te	erti	4 Homicide determined	building, etc. (Specify)				City or 10	wп, State)			
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier S Certifying Phys	ician: To the best of my knowled	dge, death	occurred at the t	ime, date and pla	ce, and due to the	cause(s) and	manner as st	tated.	
	24 h 24 h Fur	edical	(Check only 2 Medical Examination)	er: On the basis of examination and manner stated.	and/or invi	estigation, in my	opinion, death oc	curred at the time	date and pla	ce, and due to	the cause	(s)
	Fo the	Me	29b. Signature and title of certifier				se number			gned (Month,		
1	/		1 alva	ne)		H	00557	51	2-0	10-04	0	
h	.00		30. Name and address of person who co	mpleted cause of death (Item 23	Ba) (Type, F	Print)						
1	Ur		Jennifer Schmidt,				ad, Cali	fornia,	Maryla:	nd 206	19	
2. Indi	St	ate	31 Date filed (Month, Day, Year)	32. segistrar's Signature	θ 🥒		27 cm 2					
	Regist		FEB 0 6 20	06 Jan Si	1	and a						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 8.24am Physician lartha lack sor 2006 LOUISE 03 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Pay, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 M 2 M 1930 North Carolina 241 - 36 - 9565 Usual Residence of Decedent Director 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show other treumatic event, the Medical Examiner rust be notified at 1 ☐ Yes 2 ☐ No Funeral Director DE New Castle 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23s or 197 Inited 215 11. Marital Status Kd. Murral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 271s marked other than "naturel", or liter, any injury or other treumatic event, the Mental Page. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify by 3 Widowed 4 Divorced Black Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Processor 0 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Alice 2 Neal lommy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Halm Const, FL 46 woodworth Dr. (Son 1). lucker ichard 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brachwood Cemetery 2006 Durham, NC 21. Signature Funeral Savice Mensee 22. Name and Address of Facility 201 N. Gray Ave MOUSGO Congo Funeval Home Approximate Interval Between Onset and Death 23a. Part . Entarthe disease, or com shock, or heart failure. List only ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical **Examiner** Sio Sequentially list conditions, harry, leading to infractions cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off: Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 Live birth 3 Ectopic pregnancy Year in the past 12 months? 5 ☐ Other (specify) 4 Pregnant at time of death detached Division of Vital Records, P.O. 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes Hospital or Attending Physicien: 26. Place of Death Check onl one 25. Was case referred to medical examiner? Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 2 this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Natural

2 Accident 28b. Time of After t Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide determined 4 T Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 22 F020000 عوب د 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 223 wer c (OKSOYOR 20 egistrar's Signature 9 2006 Registrar

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** February 3, 2006 Julia B. Brown Jefferson 11:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Gladys Spellman Nursing Center Hyattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

April 2, 1912 Washington, DC Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 T) F 579-09-4885 93 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23a or 28a-f ehow any injury or other traumatic event, the Madical Examinating the notified at once. 1 X Yes 2 □ No Prince Georges Directo Maryland Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20721 10214 Indian Summer Court United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No African American 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Dept. of the Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Paxton Brown Betty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles B. Jefferson (son) 10214 Indian Summer Ct., Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 2/13/06 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Auneral Service Licenses 7400 Georgia Ave. N.W., Wash. D.C. mpson Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto (or as a nonsequence of) Examiner or Attending Physician: The law requires that the death certificale be executed burial-transit sician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Certification; To Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐XNo Month Day 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Respiratory failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 No certificate 1 ☐ Yes 2 ☐ No ours after death.

erai Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XXNo 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00026024 Feb. 6, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6490 Landover Road, Silver Spring, MD Lester Miles, M.D. 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature State FEB 09 2006 Registrar

ADH ANTHONY JACKSON 06-1127

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNpend item#23a.PII.27.pen/E.0854.4/17/06 III State of Maryland / Department of Health and Mental Hygiene [] [] 6

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year ANTHONY L. JACKSON **FEBRUARY** 13, 2006 1125 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3004 FORESTVILLE ROAD FORESTVILLE PRINCE GEORGES 5. Social Security Number UNK • If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1[XM 2□ F Director MARCH 19,1960 45 WASH. D.C. Usual Residence of Decedent 10a. State UNK death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits UNK. UNK. UNK Yes 2 No Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code UNK. UNK. Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. filed within 72 hours efter 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: δ Specify: 3 Widowed 4 Divorced Year or Dates: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) UNK. Department of Health and Mentel Hygiene. Important: if Item 27 le marked other then Elementary/Secondary (0-12) College (1-4or 5+) IINK. 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 end 2 should be nent of Heelth and Mentel ဥ ANDERSON JACKSON ROSETTA WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHELLE CLIPPER/SISTER 407 D. ST. S.E., WASHINGTON, D.C. 20003 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY FEB. 21, 2006 RIVERDALE, MD. permit. Depertr 21. Signature of Funeral Service Liminsee any in 22 Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. - Chambuss 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 - M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Intracerebral Hemorrhage resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed and Due to (or as a consequence of): ettending physicien Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 9 cete has been sig Liver Cirrhosis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2 □ No 24a. Was an this certificete has autopsy performed' 1 Yes 2 🗆 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check only one examiner?
1 Xes 2 No Hospital: 1 ☐ Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) SCENE Certification: To 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No the 2 Accident within 24 hours efter deatl To the Funerel Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) OCME FEBRUARY 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZABIGU 111 PENN STREET, BALTIMORE, MARYLAND, 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 21 Registrar 2006 355

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CPM 06-00872 William Johnson

.1an	i Jonnso)11	For State	State of Maryland / Depa			ZHHb	05568
			Registrar 1. Decedent's Name (First, Middle, Last		tificate of Death	Reg. 2. Date of Death	No.	3. Time of Death
	Physicia	_	1. Decedent's Name (First, Middle, Last	E JOHNSON	To	Month	04, 2006	08:20 A ^M
	/Medic		4a. Fecility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	00.20 n
	Examin	er	Peninsula Regiona		Salisbury		Wicomic	o
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp	place (State or Foreign
	Director		217-44-1655 1	VM 2□F 6/ Yrs.	Noticia Bays Floats IIII.	7-7-	44	MD
	D .	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation			0d. Inside City Limits
	faryia febo	5	NAS WAS		SBURY			1 Syes 2 No
	28a-i	ect	10e. Street and Number	MILD JACK	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	death with the Maryland me 23s or 28s-f ehow rmst be notified at	0	900 - DELAW	ARE AVE	21801		1151	9
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - Ameri Black, White,	
9	ours after death with the Marylan rel', or iteme 23e or 28e-f ehow Examiner must be notified at	F	1 Never Married 2 Married	1 Nes 2 No	☐ Yes 2 No Specify:	,		LACK
Maryland 21215-0036	72 hours after "neturel", or ite	d by	3 Widowed 4 Divorced	Year or Dates: ARMY	lent's Usual Occupation	161	o. Kind of Business/Ir	
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/lar	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Ma	ToE	WILLIAM EJ	OHNSON SR	LILL		LILLER	
lan	and and le mum	1	19a. Informant's Name/Relationship (T	0	g Address (Street and Number or Ru	ural Route Number, C.	ity or Town, State, Zi	Code)
	s 1 and 2 should of Health and Men item 27 is marks other traumatic		20a, Method of Disposition	20b. Place of Dispo) - DELAWARE	Date 200	C. Location - City or	own, State
Baltimore,	00		1 Surial 2 ☐ Cremation 3 ☐	Removal from State cemetery, crem	natory or other place)	2)21	1	Mr
Itim	permit. Pag Department Important: i any injury o		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License	11/1/11/11	Name and Address of aculity	ENNIE	TURLOCK,	PH -
Ba	permit. Departrimports any inju		I Thingellow	Royala) 91		ST. SAL	0000	MA 21801
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	/Medical		resulting in death)	Due to (or as a consequence of):	Thuosclevotic Drsea	cho citoro	caraw)	
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	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):				:
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9	tificate og phys as the	ledi						
Вох	eath certific attending p	an/N	23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of delivery	very Dav Year
). E	e dea the at	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 5 ☐ 9☐ Unknown	Other (specify)			
P.0	that the	Phy		ontributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
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tal	ician: The certificate hi rector, page	a)	25. Was case referred to medical		26. Place of De	1[A Yes 2[ath (Check only one)	THO IA I es	20140
Σ	Physicia this cer al direct	ToB	examiner? 1XXYes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	nt 3 DOA Other: 4 Nursing	Home 5 Residence	ce 6 Other (Spec	ify)
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sio	Attendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	COL L COL-	at and Number of Ov	and Court Marshare
Division of Vital Records, P.O.	or At after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, larm, str building, etc. (Specify)	reet, lactory, office	City or Town,	et and Number or Ru State)	rai Houte Number,
_	Hospital 14 hours a Funarai (29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of my knowledge, deat	h occurred at the time, date and place	e, and due to the cau	se(s) and manner as	stated.
	To the Hospital or Attent within 24 hours after death To the Funaral Director: completely filled in by the	Medical	(Check only 2 Medical Examone)	iner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occ	urred at the time, date	e and place, and due	to the cause(s)
	To the within 2 To the comple	ž	29b. Signature and title of certifier	0	29c. License number		d. Date signed (Monti	
	ct		· Carden	allamna	0.C.M.E.	Fe	ebruary 05	, 2006
	3		30. Name and address of person who	completed cause of death (Item 23a) (Type,	Print) Penn Street, Balt	imore Mai	rvland 212	.01
			31. Date liled (Month, Day, Year)	32. Registrar's Signature	Total Server, Bare			
.9	Regist	ite ar		006 Deleas H. A	parke			

			1 - For State Registrar	State of Marylar			of Health ar of Death	nd Mental H	ygiene Reg. No. 0 6	05569
	Physici /Medi		1. Decedent's Name (First, Middle Martha Raye Ki	te				2. Date of D Month Februa	ary 7, 2006	3. Time of Death 6:10 P M
	Examir	ner	4a. Facility Name (If not institution Calvert County 5. Social Security Number	, give street and number) Nursing Center 6. Sex 7. Age (In yrs.	last hirthday)		wn, or Location of I ce Freder fear If Under 24	rick	4c. County of Dea	County
à	Funeral Director		219–34–8878 Usual Residence of Decedent	1 M 2 M F 68	Yrs.			Min. (Month, L		rthplace (State or Foreign country) th Carolina
Maryland 21215-0036	s filed within 72 hours after death with the Maryland I Hygiene. other than "natural", or items 23a or 28a-f show vant, ite Mydical Experimer must be notified at	Completed by Funeral Director	10e. Street and Number 830 Pat Lane 11. Marital Status 1 Never Married 2 Married 3 Nidowed 4 Divorced 15. Decedent (Specify only highest Elementary/Secondary (0-12) 11	12. Was Decedent Ever in Under Armed Forces? 1	16a. Deced (Give life. L	10f. Zip Co 2063: Was Deceden f Yes, specify 1 Yes 2 K	t of Hispanic Origin Cuban, Mexican, f No Specify: Occupation fone during most of clierth		Specify: V 16b. Kind of Business Records Ma	ierican Indian, ite, etc. White
aryland	d 2 should be fi th and Mental H 7 is marked ot traumatic avar	To Be	17. Father's Name (First, Middle, William Jewell 19a. Informant's Name/Relationsh		19b. Mailir	ig Address (S	Annie	e Belle Ro	le, Maiden Surname) Dbins ber, City or Town, State,	Zip Code)
Baltimore, Ma	es 1 an of Heal fitem 2 r other		Wayne F. Kite 20a. Method of Disposition 1∑ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)	3 □Removal from State Mar	Place of Dispo cemetery, crem yland	sition (Name natory or othe Vets. (r _{place)} Feb Cem.	orualy 13, 2006	Cheltenham	r Town, State n, Maryland
Ball	permit. Page Department: Important: if any injury o		21. Signature of Funda 1	Lec complications that caused the deal	8:	125 Sou	uthern Ma	ryland Bl	al Home Calv Lvd., Owings	
8760,	Physician /Medical Examiner up physician up physician and physician up principle up physician up	ledicai Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect d	Scler guence of):				metra Discar	Interval Between Onset and Death
.O. Box 6	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2-€€No 9 ☐ Unknown	23c. If yes, outcome of pregnal 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	Ideath 3	Ectopic pregr			23d. Date of de Month	elivery Day Year
Δ.	w requires that the been signed by th should be detache	þ	Part II. Other significant condition	ns contributing to death but not res	ulting in the ur	nderlying caus	e given in Part I.		tobacco use contribute	to the cause of death? Probably 4 □Unknown
of Vital Records,	The law ele has b page 2 st	Completed	<u>A8p. 12</u>	hon Pren	mon	, 9		per	as an 24b. Were a prior to death? 2 No 1 Yes	
Division of Vita	i or Attending Physicien: The after death. Director: After this certificete in by the funeral director, pag	ertification: To Be	25. Was case referred to medical examiner? 1 Yes 22 No 27. Manner of Death 1 Natural 5 Pending investig 2 Accident 3 Suicide 6 Could in determined.	28a. Date of Injury (Month, Day Year) ation ool be ned 28e. Place of Injury - At h.	ER/Outpatien 28b. Time of Injury	28c.	Cther: 4 Nursi	28d. Describe	sidence 6 Other (Sp. e how injury occurred	
Ö	To the Hospitel or Al within 24 hours after of To the Funeral Direc completely filled in by	edical Cert	29a. Certifier Certifyin	g Physician: To the best of my kno examiner: On the basis of examina	owledge death	occurred at t	he time, date and p	place, and due to the	e cause(s) and manner a	as stated.
)		Medi	29b. Signature and title of certifier	and manner stated.		29c. Li	cense number	23	29d. Date signed (Mon	
	5 Sta Registr	9		who completed cause of death (Iter enthal, M.D. 11 32. Registrar Signa 8 - 8 2006	O Hosp	ital Ro		ce Freder	rick, Maryla	and 20678

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			1 - For State Registrar	State of M	aryland		artmen rtificat			nd M	ental Hy	giery Reg. N	000	05570
	Physici /Medio		Decedent's Name (First, Middle LEO	H. KOS	Н						2. Date of D		200 ^{Year}	3. Time of Death 7:10P M
	Examin		4a. Facility Name (If not institution	n, give street and number)			4b. City,	Town, or I	_ocation of	Death		4	c. County of Death	
¥	Funeral Director		Washington 5. Social Security Number 214-12-7348	6. Sex 7. Ag	Hospi e (In yrs. las 88	tal st birthday) Yrs.	Ta If Under Months		If Under 2		8. Date of Bi (Month, D Jan •]	ay, Year) Cou	mery place (State or Foreign intry) ryland
	land ow		Usual Residence of Decedent 10a. State 10b. County	/	10c. City,	Town or Lo	cation							10d. Inside City Limits
	Many a-f sh	tor	MD Mo	ntgomery		Si	lver	Spi	cing					1 □ ¥ s 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of What Cou	intry?
	n 72 hours after death with the Maryland *natural*, or Items 23a or 28a-f show culcul Exprinter man be netitied at	by Funeral I	1090 Good 11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes Give		ł			panic Orig , Mexican,	in? (Spe Puerto F	cify Yes or N Rican, etc.)	0-	U.S.A. 14. Race - Amer Black, White Specify: B.	
3-003b	2 hours	ed t		nt's Education		16a. Deced	dent's Usua	al Occupa	tion	-		16b.	Kind of Business/l	
212	within 72 ene. then "na	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4or		(Give life. l	kind of wo DO NOT u	rk done di se retired)	uring most	of workir	9			,
Z D	DO	Co	7 t h 17. Father's Name (First, Middle,	(201)		реа	tile		19 Mother	's Name	(First, Middle	Maide	Auto Co	ompany
au	d a b	o Be										_	n Sumame)	
5	should nd Men marke umatic	P	Charles E 19a. Informant's Name/Relations		- 1	19b. Mailir	ng Address	(Street a			HOWal		or Town, State, Z	ip Code)
ĭ Na	and 2 ealth a n 27 is		Richard Kos	h- Son		109	0 Gc	od I	lope	Dr	Silve	er S	Spring,	MD 20905
o G	of He		20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation	3 DRemoval from State		ce of Dispo					ate		Location - City or	
Бант	ment of tant: If it		4 Donation 5 Other (5	Specify)	Ash	n Mem			-	•	0/06		andy Sp:	
n n	permit. Pages 1 and 2 should Department of Health and Men Important: If tiem 27 is marke any injury or other traumatic once.	(Signature of Funeral Service	K. Duran	vd.	~ 2	46 N	I. Wa	ashir	ngto	n St	Roc		Home, P.A. , MD20850
	Physician		23a. Part1. Enter the disease, o shock, or heart failure Lis Immediate Cause (Final disease or condition	r complications that caused tonly one cause on each li	the death. ne. ATE	Do not ent	er the mod	of dying	, such as c	ardiac o	r respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	Price of):	12	1 1	SA	LU	RE	`		
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is listed experts.)	Due to (or as	a conseque	ence of):	51	A00	che					
6/60,	sate be executed only sician and the burial-transit	ilcal Exar	that initiated events resulting in death) Last	cDue to (or as	a conseque	ence of):	USU	1==	110	er	M	^		
O. BOX 6	death certifii e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	leath 3	Ectopic p					Ann and an inflational, and pasts	23d. Date of deli Month	very Day Year
as, r	requires that the een signed by th hould be detache	by	Part II. Other significant condition	ions contributing to death t	out not result	ting in the u	nderlying o	ause give	n in Part I.					the cause of death?
Vital Records	The lay ate has page 2	Completed	ASDO	MINAL	ANI	Wn	M 8	5M				opsy formed?	prior to death?	topsy findings available completion of cause of 2 No
<u> </u>	Physician: r this certific ral director.	o Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check only			
lon or	fune fune	 -	1 Yes 2 16 27. Manner of Death 1 Autural 5 Pendi 2 Accident invest	28a. Date of Inju		R/Outpatier 28b. Time of Injury		28c. Injury Work	at ?	2			6 Other (Specured	afy)
DIVISION	To the Hospital or Attending Pr within 2 Hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could 4 Homicide determ	mined 288. Place of in	jury - At hom tc. (Specify)	ne, farm, str	reet, factor	y, office		1	28f. Location City or T			ral Route Number,
	he Hospit n 24 hour he Funera pletely fills	edical (29a. Certifier 1 Certifyi (Check only 2 Medical	ing Physician : To the best I Examiner: On the basis of and manner st	of examination	ledge, deati on and/or in	h occurred vestigation	at the tim	e, date and inion, deati	d place, a	and due to the	e cause e, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	To To Land	Ž	29b. Signature and title of certific	SAAM	(M		29	D-	number	181	4	29d. C	Date signed (Month	7. Dey, Year) 2006.
	1		30. Name and address of person		*									
	0.7.61		Dr. Shahid 31. Date filed (Month, Day, Year	Shamim, M	D 760 rar's Signatu	00 Ca	arrol	.1 A	ve Ta	akor	na Pa:	rk,	MD 209	12
	Sta Registi			8 2006	Serve of	U. 19	porti							

State of Maryland / Department of Health and Mental Hygiene 0557 1- State Registra Amend Item #10a-f PerINf g852 9702406 of Peath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 3. 2006 10:36 A^M Feb. Woodrow Wilmon Keys /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Magnolia Gardens Nursing & Rehab Center Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 23, 1931 6. Sex 14 M 2 F 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours 74 Yrs. Maryland 579-42-4047 Director Usual Residence of Decedent 10b. County Polk 10d. Inside City Limits 10c. City. Town or Location show fförida nam 27 is marked other then "naturel", or Items 23e or 28e-f show other traumatic avent, it e Madical Examiner must be notified at Beltsville Lakeland 1 ☐ Yes 2 X No Director the 10g. Citizen of What Country? 10f. Zip Code 2177 Sunstone Drive 33813 4509 Wicomico Avenue -20705 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene.
Important: if item 27 is marked other then "naturel", or iten any hijury or other traumatic avent, the Medical Examinations. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: 1950–1953 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fork Lift Mechanic Industrial 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jessie Felice Hurd Wilmon Pittman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stephan Ray -nephew 4509 Wicomico Avenue Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State M Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 2/9/2006 Brentwood, Maryland A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses BoraltanV.ddrBorfaWardt Funeral Home, PA Donald 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARCINO MA COLON WITH METHOTASIA Priysician i year disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consumence of Examine fany leading to immedicause. Enter Underlying Cause (Disease or injury use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Box 68760 requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death P.O. the ğ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe 1 Yes 2 No 3 Probably 4 Unknown CANDIORESPIRATING ADDEST Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an MELLIN autopsy performed? Yes 2 No 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending after death. 2 🗌 No 1 Tes investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier FEBRUANS 4,2006 Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 QUEENSBURY Rd HYATTSVILLE MI) 20181 URE MID 17 31. Date filed (Month, Day, Year) State 0 8 2006 FEB Registrar

	1- For Amend Item 19 per III, 6856,0	Certificate of Death	Reg. No.	12
Physician	Decedent's Name (First, Middle, Last) Mary Jane King	2 F	Month Day Year	of Death
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	25A M
	1116 Kuhn Ave	Hagerstown	Washington	
Funeral Director	5. Social Security Number 216-22-8725 Usual Residence of Decedent	Months Days Hours Min.	Date of Birth (Month, Day, Year) Parch 14 1928 9. Birthplace (State Country) Arryland	_
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show important: If Item Medical Evarither must be notified at ones. To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town	or Location	10d. Inside	City Limits
a-f sh iffed	Maryland Washington Ha	gerstown	X□∧	es 2□No
iner must be rotified	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
rail	1116 Kuhn Ave	21740	U.S.A.	
in	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 N No	 Was Decedent of Hispanic Origin? (Specific Mexican, Puerto Richards) 	y Yes or No- lan, etc.) 14. Race - American Indian Black, White, etc.	1
à	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐XNo Specify:	Specify: White	
siete	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry	
Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Seamstress	Dress Manufactur	er
BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (A	First, Middle, Maiden Sumame)	
P	William C. Tedrick	Rhoda B	. Hawbaker	
	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b.	Mailing Address (Street and Number or Rural F	toute Number, City or Town, State, Zip Code)	
		910 Oak Hill Ave., Hage		
	1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery	Disposition (Name of Dat , crematory or other place)	Edd. Eddard. Dily d. 14mi, Claid	
	' 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	1's Cemetery 2-16-2		
SUCE.	21. Signature of Furieral Service Licensee		las A. Fiery Funeral H	
	23a. Part 1. Enter the diseas or omplication that called the death. Do no shock, or hear failure. List only one calls on ear fine.		. Hagerstown Maryland aspiratory arrest, Approxim	nate
n al	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence or	Cencer	Interval I Onset ar	
er	Sequentially list conditions b.	<i>p</i> -	Au-	
dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause Underlying that initiated events):	-	
dicai Ex	resulting in death) Last Due to (or as a consequence of d.):		
	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery	
Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month Day	Year
ieted by Physician/Me		the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of	of death?
	I have Obstructure	Pu (moray	1 Yes 2 No 3 Probably 4	□Unknown
ompieted	direct	i	24a. Was an autopsy performed?	gs available of cause of
O	25. Was case referred to medical	26. Place of Death (6		
ToB	examiner? 1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	Othor	5 ☐ Residence 6 ☐ Other (Specify)	
i i	27. Manual f Death 28a. Date of Injury 28b. Ti	me of 28c. Injury at 28c wy Work?	I. Describe how injury occurred	
satic	2 Accident investigation	M 1 Yes 2 No		
Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office 28	Location (Street and Number or Rural Route N City or Town, State)	umber,
edicai (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, one) 2 Medical Examiner: On the basis of examination and and manher stated.	death occurred at the time, date and place, and for investigation, in my opinion, death occurred	I due to the cause(s) and manner as stated. at the time, date and place, and due to the caus	e(s)
Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year	-)
	30. Same and address of person who completed cause of death (Item 23a) (1	W 23623	Tehnory 13, 2	och
	Forder 1+ KAS II MA	11110 holled Co.	on Rd Hearton	had had
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	/	11.080.100	yv - 117

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2/35AM re 2006 JOHN KENLON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WICOMICO SALISBURY, MD. 21804 SALISBURY REHAB & NURSING CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-26-1942 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours **™** M 2□ F Months BALTIMORE, MD. 63 Director 578**-**56-5171 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County s 23a or 28a-f ehow 1 XYes 2 No SALISBURY Directo WICOMICO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21804 200 CIVIC AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ XYes 2 □ No NAVY If Yes, Give Year or Dates: 1959-61 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 7 is marked other then "natural", or items traumatic event, the Medical Examination 11. Marital Status 1 □ Never Married 2 □ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) HOSPITAL TRANSPORTER 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental EMMA THOMPSON JOHN KENLON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.1 Department of Health ar Important: If item 27 is any injury or other trau once. 607 NOTTINGHAM DRIVE, SALISBURY, MARYLAND 21804 PAUL KENLON - BROTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State CREMATORY OF DELMARVA 02-10-2006 DELMAR, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature of Meral Service Licensee 705 EAST MAIN STREET, SALISBURY, MARYALND 21804 m 283 Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Interval Between On at and Death Immediate Cause (Final-Physician disease or condition resulting in death) /Medical to (or as a consequence of): Examiner 2017 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due-to (or as a conse Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Tonce attending physician and that initiated events resulting in death) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Tes this certificete 2 1 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Cther: 4 Jursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manne Death 28b. Time of 1 Matural 5 Pending s after dec. 1 🗌 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie (Check only one) and manner stated. 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number Ce 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 CIVIC AVE., SALISBURY, MD. WILLIAM ROBINS, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 0 9 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** February 15, 2006 11:20AM MAE **IRENE** KLINE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Reeders Nursing Home Boonsboro If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□ M 2♀ F Yrs. Director 208-24-1370 1924 Jan. 13, Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits traumatic avant, the Medical Examiner must be notified at 1√2 Yes 2 No Frederick Directo Maryland Myersville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 419 Main Street 21773 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 257 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 Divorced marked other then "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Cyrus Welty Early Susan Irene Pryor ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Stanley C. Kline / husband 419 Main Street, Myersville, MD 21773 Department of Health Important: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Grossnickle Ch of Breth 2-18-06 Myersville, Maryland 21. Signature of Juneral Service Ucensee 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart if ture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician unities Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be execuled Due to (or as a consequence of) Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed certificate 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Mursing Home 5 Residence 6 Other (Specify) P 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D32518 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Guedenet 21 Wyand Drive, Keedysville, Maryland 21756 301-432-2222 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/200

Registrar

		-	For Stata	ricase			and / De		nt of H	Health a		ental Hyg	giene 18.00	6	0557	75
	- No. 47		Registrar 1. Decedent's Name (F	First, Middle, Las	t)							2. Date of Dea	th	-	3. Time of D	Death
-27.4	Physicia		MARCIA AN	N SWEEN	EY LIND	BERG					Ţ	Month Februa	Day	Year 006	0231	М
	/Medic Examin		4a. Facility Name (If no					4b. Cit	y, Town, c	or Location of		cor ua	4c. County	of Death	- V431	
	A 19 19	٠.,	Memoria		ital				Eas	t on If Under			Talb	ot_		
	Funeral		5. Social Security Num	1	ex □M 2 X F		rrs. last birthd CE Yrs	Month	er 1 Year S Days	Hours	Min.	8. Date of Birth (Month, Day	Year)		place (State or ntry)	Foreign
	Director	-	332-34-08 Usual Residence of De				55 Yrs					SEPT. 1	, 1940	1L_		
	yland		10a. State 10	Ob. County		10c.	City, Town o	r Location						1	0d. Inside City	•
118	e Ma	ctor	MD	QUEEN A	NNE'S		GRASON	TLLE							1 🗌 Yes :	2 X]No
	vith th	Director	10e. Street and Number						ip Code				10g. Citizen of V	Vhat Cour	itry?	
	seth v	Funerai	10 FAIRWA	Y ISLAN		edent Ever in	n II S		1638	Hispanic Ori	nin? (Sner	ofy Yes or No-	USA 14. Baci	e - Americ	an Indian.	
10	fter d	Fun	 Marital Status Never Married 	2 Married	Armed F	orces? 2 👿 No	11 0.3.					offy Yes or No- lican, etc.)	Blac	ck, White,	etc.	
036	ai', o	þ	3 Widowed 4		ff Yes, G Year or [ive		1 🗌 Yes	2 ∏ No	Specify:			Specify	WHI	TE	
erg 21215-0036	within 72 hours affer deeth with the Maryland ene. 906. 107 Itan "natural", or items 23e or 28e-f ehow he Madical Examiner must be notified at the Madical Examiner must be notified at	Completed	(Specify	5. Decedent's Ed only highest gra	lucation de completed))	(G	ecedent's Us	vork done	durina mosi	t of workin	ng	16b. Kind of Bu	usiness/Ind	dustry	
r.g.	within ne.	mpi	Elementary/Seconda			(1-4or 5+)		e. DO NOT					TMOTIDA	MOT		
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n d	d be ental	To Be	FRANK ZIM									RIGGS				
Li	s 1 and 2 should be filed within 72 hours after deeth with the Marylan ferleath and Mental Hygiene a ferleath and Mental Hygiene between \$28 or 28e-1 ehow tem 21 is marked other than "natural", or frems 23a or 28e-1 ehow other traumatic event, the Madical Examiner must be rediffied as	-	19a. Informant's Name		Type, Print)		19b. M	ailing Addre	ss (Street				r, City or Town,	State, Zip	Code)	
	and 2 saith a n 27 is		LYNNE LAV	ANCO/ST	EP-DAUG	HTER	10 9	TARBO	ARD (COURT,	BRI	CK, NJ	08723			
S	of He of He fiterr		20a. Method of Dispos		Removal from		 b. Place of Di cemetery, 	sposition (N crematory o	ame of r other pla	100)	Da	ate	20c. Location -	City or To	wn, State	
i	Pages ment of ant: If it ury or o	1	4 Donation 5	Other (Specif))	S'	T. PET	ER'S (CEMET	ERY 0	2/09	/2006	QUEENS	TOWN	, MD	
Marcia S. Baltimore,	permit. Pages Department of I important: if it any injury or o		21. Signatur o Furie	H.	He	16		FELLO 106 S	WS, I HAMR	OCK RO	NBEIN DAD,	CHESTER		RAL 1 1619	номе, Р	.A.
100	99 62		23a. Part1. Enter the shock, or heart f	disease, or compailure. List only	olications that one cause or	eaused the deach line.	leath. Do not	enter the m	ode of dy	ng, such as	cardiac or	r respiratory ar	rest,		Approximate Interval Betw Onset and D	veen
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	/Medical Examiner		resulting in death)	(Due to	(or as a con	sequence of):	con	-61							
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o.	the de	ysic	1 ☐ Yes 2 ☑ N 9 ☐ Unknown	10	9☐ Unkr		or dodan	3 L O(1161)	Specify_							
Division of Vital Records, P.O	w requires that the de been signed by the should be detached	y P	Part ff. Other significa			death but not	resulting in th	ne underlying	g cause gr	ven in Part I		23e. Did to	obacco use cont	iribute to th	he cause of de	eath?
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000	aw re	plet		/								24a. Was			opsy findings a	
ĕ	sician: The law certificate has t irector, page 2 s	Completed										perfo	rmed?	death? 1 □ Yes		
/ita	ysician: is certific director,	Be	25. Was case referred examiner?	to medicaf	112-1						e of Death	(Check only o	ne)			
of	Physi this c	2	1 Yes 2 No	>			2 ER/Outpa		28c. Inju				dence 6 Oth		(y)	
5	ding h. After funer	tion	1 Naturai	5 Pending investigation	F	of Injury oth, Day Yea	r) 200. Till		Wo	ork?]Yes 2.∐		.00. 50001150 1	iow injury occur	100		
ISI	Attending r deeth. ector; Atter by the funer	Certification:		6 Could not be	28e. Plac	e of Injury - A	At home, farm	, street, fact					Street and Numb	ber or Rura	al Route Numl	ber,
á	s after	Cert	4 🗌 Homicide		build	ding, etc. (Sp	ecity)					City or Tow	vn, State)			
	To the Hospitel or Attending Phys within 24 hours after deeth. To the Funerel Director: After this completely filled in by the funeral di	Medical (Certifying Ph Medical Exam	niner: On the I)
	within To th compl	Me	29b. Signature and titl				/	:	29c. Licen	se number			29d. Date signe	d (Month,	Dey, Year)	
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_	and Admittable struytes		30. Name and address													
			HAIOU LAU		M.D.,	219 S	OUTH W	ASHING	TON	STREET	r, ea	STON, N	D 2160)1		
	Sta Registr		31. Date filed (Month,	FEB -	9 2006	Hegistar's S	ignature &	19	whi							

State of Maryland / Department of Health and Mental Hygiene 🖺 🕦 🕞 For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 8:30 a Charlie Lee, Jr. Feb 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Charlotte Hall Veterans Home 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. St. Mary's Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1**∑**M 2□F Yrs. Director 8/3/1915 239-24-1678 90 NC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or 28a-1 show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23a or 28s-1 show any injury or other treumatic event, it a Medical Examinar must be notified at once. 1 Yes 2 No Director MDSt. Mary's Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29449 Charlotte Hall Road 20622 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ∑Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Produce 12 Fruit Stand Vendor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Charlie Lee, Sr unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9798 Howes Road, Dunkirk, MD 20754 e et Disposition (Name of Date 20c. Location - City or Town, State Annie Rawlings/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/8/06 S. Memorial Gdns Dunkirk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Raymond-Wood F.H., P.A. 6 PO Box 430, Dunkirk, MD 20754 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Postinson disease /Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Attending Physician: The law requires that the death certificate be executed Due to lor as a consequence of): and resulting in death) Last Box 68760, attending physiclen Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No been si 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 9 No 1 ☐ Yes 25. Was case referred to dical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 €No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this nours after death.

neral Director: After this filled in by the funeral d 27. Manne eath 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 0 To the Hospitel o within 24 hours af To the Funeral Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29h Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00060120 AAMOW H MD Prince Frederick, MD 20678 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) loo Hospital Rd A. wael Hagethmn 32. Registres Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

			1- State of Maryland / Dep	eartment of Health and Mertificate of Death		E. G. C. C.	05577
			Decedent's Name (First, Middle, Last)		2. Date of Death	J. No.	3. Time of Death
	Physici /Medio		Carl George Lavsa, Sr.		Month February	7, 2006	5:00 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			803 Coxswain Way, #307	Annapolis		Anne Ar	undel
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	pplace (State or Foreign untry)
и	Director		102–14–7035 ¹ \(\overline{\mathbb{Y}}\) M 2 □ F 83 Yrs.	Month's Bay's Hours IVIII.	3-10-19	22 Nev	W York
	pue *		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or It	ocation			10d Inside Ob Limits
	Aaryli e ho	5					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th the Maryland or 28a-f ehow	Director	Maryland Anne Arundel Annapol 10e. Street and Number	10f. Zip Code	100	. Citizen of What Co	
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	thin 72 hours after death with the Maryland e. Madical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Amer	ican Indian.
۵	or the	F	1 ☐ Never Married 212 Married Armed Forces? 112 Yes 2 ☐ No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
215-0036	ret', c	l by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1943–45	1 ☐ Yes 21 No Specify:		Specify: Wh:	ite
ה ה	72 honatu	Completed		edent's Usual Occupation a kind of work done during most of worki	16	b. Kind of Business/I	ndustry
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ylan		7	Otto Simon Lavsa		th Garris		
Z	s 1 and 2 should if Health and Mer item 27 ie marke other traumatic			ing Address (Street and Number or Rura			
a)	1 and lealth om 27 ther tu		Theodora L. Lavsa/ Wife 803 20a. Method of Disposition 20b. Place of Disp	Coxswain Way, #307			
0	if its		1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State cemetery, cre	matory or other place)		c. Location - City or 1	
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g	permit. Pages 1 an Depertment of Heal Important: if Item 2 any injury or other ance.			2. Name and Address of Facility Geo			
	45244			2973 Solomons Islar			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.		or respiratory arrest		Approximate Interval Between Onset and Death
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	/Medical Examiner		Due to (or as a consequence of):	2 -1 -			
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	ted nsit	Examiner	cause. (Disease or injury	ntlactacer Carenons			
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Ŏ	death e atten	icla	in the past 12 months? 1 Ves 2 No 4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
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r.	The law requires thet the ate hes been signed by the pege 2 should be detached.	by P	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
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		a)	25. Was case referred to medical	26. Place of Death		1 ☐ Yes	2 No
_	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatie	Other		e 6 ☐Other (Spec	(64)
5	g Ph er th		27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe how		197
NISIOII NISIOII	ath.	ate	t Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	M 1 Yes 2 No			
<u> </u>	er de recto by th	tt	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28t. Location (Stree City or Town, S	et and Number or Rui	al Route Number,
5	s oft	Certification:	building, etc. (Specify)		City of Town, 3	state)	
	To the Hospitel or Attending Physicien: within 24 hours elter death To the Funeral Director; After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physicien: To the best of my knowledge, dea 2 ☐ Medical Exeminer: On the basis of examination and/or is and manner stated.	h occurred at the time, date and place, a westigation, in my opinion, death occurre	and due to the caus ed at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month)	Day, Year)
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		}	30. Name and address of person with completed cause of death (Item 23a) (Type	Print)		11/06	
			Custos America mon 900 Ractor	Print)	fanna porti-	mnoi	101
1	Sta	te	31. Date filed (Month, Day, Year) 32 segistrar's Signature	- 100 m 200 m	Allo LICHTS	11111 ~	70
	Registra		FEB 0 9 2006	and I			

State of Maryland / Department of Health and Mental Hygiefie 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician 3:01 Ам February 5, Oliver Alexander Lyon 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Marys St. Marys Hospital Leonardtown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Director 217-36-6512 80 Yrs. Maryland Nov 15, 1925 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 □ Yes X□ No Director St. Mary's Maryland Clements 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 "naturel", or Items 23a 20624 23544 Hurry Road USA Funerai filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status l □Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy Importent: If Item 27 is marked other any lighty or other traumatic event, sone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Irene Oliver Alex Jarett Lyon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Lyon / Wife 23544 Hurry Road Clements MD 20624 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb 10, 2006 Metropolitan Crematory Alexandria, VA 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Mardener P.O. Box 270, Leonardtown, MD 20650 ichael leur 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each or complications that caused the death. Go not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons-Examiner -transit Physician: The law requires that the death certificate be executed and Due to (or as a consequence of); ettending physicien a for use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) ed by the detached Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cete hes I page 2 s autopsy perform 1 ☐ Yes 2 ☐ No of Vital 1☐ Yes 2027 No. Be 25. Was case referred to medical 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ø No 1 🗌 Inpatient 2 PER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After Division Hospitel or Attending 1 Natural Injury 5 Pending death. 1 □ Yes 2 □ No investigation 2 Accident the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours e To the Funerel C 29a. Certifier (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) se of death (Item 23a) (Type, Print) 30. Name and address of person who complet to Jarboe, M.D. 24035 Three Notch Road Hollywood MD 20636 James P 31. Date filed (Month Day, Year) 32 Registrar's Signature 2006 FEB 0 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Thomas Earl Lynch, Jr. February 2006 3:17 P. M /Medical 4a. Facility Name (If not institution, give street and number)
Malcolm Grow Medical Center 4c. County of Death 4b. City. Town, or Location of Death Examiner Camp Springs
If Under 1 Year | If Under 24 Hrs. Prince George's Andrews Air Force Base 5. Social Security Number Sex 1□M 2□F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min 38 Yrs Director 217-02-9233 1/7/68 Maryland Usual Residence of Decedent 10a State 10d. Inside City Limits 10b County 10c. City, Town or Location 27 is marked other than "naturel", or items 23a or 28a-f ehow traumatic event, the Madical Examinar must be notified at Director Md. 1∏Yes 2∏No P.G. North Brentwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4508 41st Avenue 20722 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. illed within 72 hours after 1 □ Never Married 2 □ Married African-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify 3 ☐ Widowed 4 反 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nursing Company 3 yrs. Nurses Recruiter 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be Mental Thomas E. Lynch, Sr. Vicinthia Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Healey/Step-father item 27 4508 41st Ave., N. Brentwood, Maryland 20722 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it eny injury or o 1

Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cem. 2/10/06 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Md. 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 21. Signature of Funeral Service Licensee and 20019 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Human Immunodeficiency Virus Infection disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the deteched f P.O. 9 Unknown 9 Unknown been signed by should be detec Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 ☐ Loknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Tes 2□ No 2 DNO 1 Tes After this certification, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO Certification: To 1 Yes 1 Inpatient 2 PR/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No nerei Director: A filled in by the fr 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide or / within 24 hours 1 Territhing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the dauce(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medicai (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and tyle of certifier 29c. License number D0026024 February 8,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lester Miles, M.D. 6490 Landover Road, Landover, Maryland 20785 31. Date filed (Month, Day, Year) State FEB 0 9 2006 Registrar

Box 68760,

Division of Vital Records, P.O.

State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 🕤 05580 State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death _Month Year **Physician** FEBRUARY 6, 2006 1215 MARGUERITTE /Medical LAVELLE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Peninsula Regional Medical Center Salls M. M.

If Under 1 Year If Under 21 Hrs.

Hours Min. 100MICU 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F 214--58-0001 55 Yrs. Feb.4,1951 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f shov the Medical Examiner must be notified at 1. Yes 2 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 Overlook Dr. 21804 Items 23s USA deeth v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced "natural", or 1 ☐ Yes 2 No Specify: Specify: White Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "na any injury or other traumatic avent, the Medicapine. College (1-4or 5+) Elementary/Secondary (0-12) 11 Receptionist Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Theodore N. Wheeler Mary Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rodney M. Lavelle/ Husband 107 Overlook Dr., Salisbury, MD., 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 DBurial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 2/11/06 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cedar Hill Funeral Home 21. Signature Fureral Service Licensee 4111 Pennsylvania Ave., Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END STAGE EMMONIC OBSTRUCTIVE PHLMONARY DISEASE **Physician** YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 □Ectopic pregnancy 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERLY DISEASE 1 Yes 2 No 3 Probably 4 Unknown CARONARY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed MELLITUS DIABETES this certificete 2 No 1 ☐ Yes After this certification funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No death. 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00062916 FEBRUARY 07, 2006 MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 SOUTH DIVISION SUITE B SALISBART, MO 21804 SVETLAND GUTTERNEZ 31. Date filed (Month, Day, Year) State

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Lee 000 DM Marta 06 /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HUSBI. 8. Date of Birth (Month, Day, heverly < If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Gountry) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 C Yrs. 577-96-2114 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c City Town or Location 10b. Count 10a State or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygene.
and: If items 23s or 28s-1 show and: It items 23s or 28s-1 show and it it items 23s or 28s-1 show and other than "natural", or items items and the notified at any or other traumatic event, if a Medical Estrictural be notified at 1 Pres 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ace 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 1 10 Yes 2 10 Yes Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be navious Lee tarold 2 19b. Mailing Addr. (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ierdole Crematori 06 Department iverdale 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address / Facility 22 Willia 767 8/3 Potomac Ave SE Wushington DC 20003 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acute Physician lnein i disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner extensi Due to (a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner inding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IE EEMALE . If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ģ 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ cate has been signed i page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Winknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2□ No certificate 1□ Yes Hospital or Attanding Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٥ 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA his Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Diractor: in 24 hour.
I the Funeral Dirac. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 30.

Registrar
DHMH 17 Rev 1/2001

FEB10

32. Registrar's Signat

Kevin Lance Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Unpend item#5,23a,27,28a-f,perFb, ME,0853, 3,2.06 TT State of Maryland / Department of Health and Mental Hygiene 06-01071 05582 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year **Physician** KEVIN **JAMES** LANCE 9:22 February 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday)
45 Yrs. 8. Date of Birth Month, Day Year I/14/1961 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1⁄2 M 2 ☐ F **Funeral** Months 217-74-6755 217-74-6755 Yrs. Maryland Director Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County **e**how ir then "natural", or iteme 23a or 28a-f ehov the Medical Examinar must be notified at Baltimore City MD 2041 Grinnalds AVe 1 ¥es 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 USA 2041 Grinnalds Avenue filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1XXIIever Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specwhite δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) UNKNOWN College (1-4or 5+) Bar/Restaurant Bouncer is 1 and 2 should be filed in of Health and Mental Hygic item 27 is marked other other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Κ. Fink Harry Lance ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 412 Main Street, Delta, PA 17314 Caetlyn Gilley- daughter f Health item 27 i 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1
Depertment of H
importent: If itel
any injury or ott cemetery, crematory or other place)
Evans Eagle Crematory 1 Burial 2 Cremation 3 Removal from State 2/15/06 Leola, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Harkins FH Inc Delta, PA 17314 Approximate Interval Between Onset and Death mmediate Cause (Final Physician Narcotic intoxication and cocaine ethanol use disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 98 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death signed by the aid be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🕅 3 Probably 4 Unknown been si should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ ★ Sas 2 □ No cate has l certificate 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 2 this After thi 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27 Manner of Death Certification 5 Pending investigation t Natural 1 ☐ Yes 2√☐ No M Fnd 2/11/06 unk ınk 2 Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 2041 Grinnalds Ave. 3 Suicide 4 | Homicide Baltimore, MD To the Hospital o within 24 hours aft To the Funeral Di Found at residence 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME February 13, 2006 rson who completed cause of death (Item 23a) (Type, Print) @18015,00 Whyla. 111 Penn Street Baltimore, Maryland 21201 31. Date liled (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

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CERTIFICATE #

2006-05583

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CERTIFICATE #

2006 - 08771

			1 - For State of Maryland / Department	artment of Health and M rtificate of Death		ene 006	05584
		. %	Decedent's Name (First, Middle, Last)		2. Date of Death Month	1	3. Time of Death
	Physici /Medi		Mark T. Millings		Feb.	6, 200	
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of E	
		ш	8702 Devon Hill Drive	Ft. Washingto			e Georges
п	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Feb. 4,	Year) 9.	Birthplace (State or Foreign Country) ashingtonDC
Ц	Director		Usual Residence of Decedent		rep.4,	TADT M	asningtonDC
	/land		10a. State 10b. County 10c. City, Town or Lo	ocation	······································		10d. Inside City Limits
	Man	to	Md. Prince Georges Ft. W	Jashington			1 X Yes 2 □ No
	or 284	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of Wha	t Country?
	1h wit	alD	8702 Devon Hill Drive	20744		USA	
	r dea	iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - A	American Indian,
36	or It	y Fu	1 Never Married 2 Married 1 Yes 2 No 1971	1 ☐ Yes 3/□ No Specify:	riicari, etc.)	Specify:	Vhite, etc.
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2	filed Hygi other	ŭ	17. Father's Name (First, Middle, Last)	18. Mother's Name			Indubbly
Maryland 21215-0036	ould be Mental arked o	To Be	Joseph Durham		ie Mili		
ary	should ind Men s marke umatic	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	ng Address (Street and Number or Rura	al Route Number		e, Zip Code)
	1 and 2 Health a tem 27 is		Bernadette Millings (Wife) Ft.	2 Devon Hill Dr Washington, Ma	rvland	2074	4
altimore,	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28e-f show or other traumatic event. If a Mudical Exercipation at the colling as		20a. Method of Disposition 20b. Place of Dispo	osition (Name of matory or other place)		Oc. Location - City	
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at	permit. Pages 1 am Department of Heall Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	Name and Address of Facility	noral S	Corrido	
<u> </u>	207299	0 1	1 (alph E. Wellson 767 1	Name and Address of Facility 1ph Williams Fu 813 Potomac Ave	·,SE; V	Vashing	ton,DC 20003
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac c	or respiratory arres	st,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	CANCER			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
W.	4	<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				_
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury				
	akecu al-tra	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760	icate be executed physician and s the burial-transit	dlcal	L _a				
9	tificat ig phy as th	ledle					
Вох	The law requires that the death certific the has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	75-to-i		23d. Date of	delivery
	deat e att	sicia	1 Yes 2 No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year
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	res tha igned be def	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.			e to the cause of death?
Records,	w require been sli should b	Completed	DIABETES MELLITUS		1 L Yes	2 2 No 3 C	Probably 4 Unknown
ပ္သ	e law has b	nple			24a. Was an autopsy	24b. Were prior	autopsy findings available to completion of cause of
					performe	No 1 🗆	1? ∕es 2□ No
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death			
o	Phys r this ral di	. T	1 ☐ Yes 2 ÛNo ☐ Inpatient 2 ☐ ER/Outpatien 27. Manner of Death 28a. Date of Injury 28b. Time of		ne 5 Residen 28d. Describe how		Specify)
O	ding Ith.	tlon	1 ☐Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	LOG. DOSGIDO NON	rinjury occurred	
Division	If or Attandi after death. Diractor: A I in by the fu	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str		28f. Location (Stre	et and Number or	Rural Route Number.
ā	al or s afte	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attanding within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune		29a. Certifier (Check only 1 Medical Examinar: On the basis of examination and/or in	n occurred at the time, date and place, a	and due to the cau	se(s) and manner	as stated.
	the H in 24 the F pplete	ledical	(Check only 2 Medical Examiner: On the basis of examination and/or invane) and manner stated.	restigation, in my opinion, death occurre	ed at the time, dat	e and place, and o	due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number		I. Date signed (Mo	
0	(1)		· amjardsome MD	D16619	1	- ebruny	- 8, 2006
2	(3)		30. Name and a toriss of person who completed cause of death (Item 23a) (Type,				
1	Sta		Dr. Corazon Soares 3 Midcres 31 Date filed (Month, Day, Year) 2. Registrar's Signature	st Ct., Towson,	maryla	na 21	.286
	Registr	9 100	FEB 0 8 2006	W			

	4	For	State of M	1aryland						Mental Hy	giene	006	055	85
		Stete Registrar			Cei	rtificate	e or L	Jeatn		2. Date of D	Reg. No.	000	3. Time	-
Physician		1. Decedent's Name (First, Middle, La								Month	Day			
/Medical	ŀ	MELVIN LEE MUI 4a. Facility Name (If not institution, give		r)		4h City	Town, or	Location (of Death	FEBRU.		9 200 County of De		9 P
xaminer					ருப	BETH			0. 20			ONTGO		
uneral		NATIONAL INSTIT	ex 7. A	Age (In yrs. Ia		If Under	1 Year	If Under	24 Hrs. Min.	8. Date of B. (Month, D	rth	9. B	irthplace (State	or Foreign
ctor		223-50-9478	MM 2□F	68	Yrs.	Months	Days	Hours	MIII.	Dec.	5,19	37 Ge	õrgia	
8	-	Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	ocation							10d. Inside	City Limits
To Be Completed by Funeral Director	- 1		± 0 m			,041.011								s 27 No
ect	5	VA Arling 10e. Street and Number	COII	Non	Е	10f. Zip	Code				10g. Citi	zen of What (Country?	
Ö		1422 S. Queen	Street			222					USA			
Completed by Funeral Director		11. Marital Status	12, Was Deceder	nt Ever in U.S	3. 13.	Was Deced	lent of Hi	spanic Or	igin? (Sp	pecify Yes or No Rican, etc.)	0-	14. Race - An Black, Wh	nerican Indian,	
Ē		1 Never Married 2 Married	Armed Forces 1 Yes 2 If Yes, Give	No		1 ☐ Yes 2				Trican, etc.)		Specify: B		
þ		3 Widowed 4 Divorced	Year or Dates	s:							1 101 15			
ete		15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	il Occupa rk done d se retired	ition <i>luring m</i> os	st of wor	king	160. K	nd of Busines	sylindustry	
amo		Elementary/Secondary (0-12)	College (1-4o	r 5+)		ente		,			Bui	lding	Contr	acto
ပိ	5	17. Father's Name (First, Middle, Last)					18. Moth	er's Nam	e (First, Middl	e, Maiden	Sumame)		
To Be		George Mullins						Reay	a N	lahone				
	1	19a. Informant's Name/Relationship			19b. Maili	ng Address	(Street a	ind Numb	er or Ru	ral Route Num	ber, City o	r Town, State	, Zip Code)	,
		Constance Mull	ins/Wife					n St	- • •		_		22204	±
	1	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 [Removal from Stat	20b. Pl	ace of Dispo metery cre asan loria	psition (Name	ne of therelac	e)		Date			or Town, State	
		`4 □ Donation 5 □ Other (Speci	y)	Mem	oria	I Par	ck 1	10					e,Vir	
9500		21. Signature of Funeral Service Lice	A										me, IN VA 22	
	+		unications hat caus	ed the death								arra,	Approxim	ate
		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final								-1: -1	(1.1	Interval B Onset and	etween d Death
n al		disease or condition resulting in death)	a.	s a consequ		Taile	NE "	20	order	1 to Ven	tribule	V HICHW	Minn	45
r	1		n Funda		1 .	erial	Si	05/5	fro	m Ones	mer	ia	Day	19
ē	2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		as a consequ			1						1 200 1	
Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Hope	ste	and	Re	na	fo	rilu	ne			week	5
ũ	3	resulting in death) cast	Due to (or a	as a consequ	ience of):									
dical		•	d											
Physician/Medical Examin		IF FEMALE:	23c. If yes, outcom	ne of pregnar	ncy							23d. Date of c	delivery	
clan	3	23b. Was decedent pregnant in the past 12 months?	1□Live birth 4□Pregnant	2 Fetal	death 3	⊒Ectopic pr ⊒ Other <i>(sp</i>						Month	Day	Year
S	2	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	1										
Completed by Physician/Med		Part II. Other significent conditions	contributing to death	but not resu	ılting in the u	ınderlying c	ause give	en in Part	I.	23e. Dio	tobacco	use contribute	to the cause o	f death?
ed t										1 [Yes 2	2(No 3□	Probably 4 (□Unknown
o Be Complet										24a. We	ODSV	prior t	autopsy finding o completion of	s available cause of
l l										per 1 ☐ Yes	formed?	death 1 □ Y		N/A
Be (25. Was case referred to medical examiner?	11				0.4		e of Dea	th (Check only	one)			
P	2	1 ≥ Yes 2 □ No	Hospital: Inpa		ER/Outpatie 28b. Time o			4 🗆 N	ursing H	ome 5 ☐ Re 28d. Describe			pecify)	
j	2	27. Manner of Death 1 Natural 5 □ Pending		Day Year)	Injury	M M	8c. Injun Worl	γαι ∢? Yes 2.[No	284. Describe	710# 11110	ly occurred		
licat	5	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	OF TOO Place of	Injury - At ho	me, farm, st			16	,,,,,				Rural Route Nu	ımber,
Certification:		4 Homicide determined	building,	etc. (Specify	")		,			City or T	own, State	•)		
a C	2	29a. Certifying P	nysicien: To the be	st of my know	wledge, dea	th occurred	at the tin	ne, date a	nd place	, and due to th	e cause(s) and manner	as stated.	-(-)
Medical Certification: 1	2	(Check only 2 Medical Exa	miner: On the basis and manner		ion and/or ir	nvestigation	, in my o	pinion, de	ath occu	rred at the time				
M		29b. Signature and title of certifier	a 15	/ / / .	1			e number		(Illing	29d. Da	te signed (Mo	onth, Dey, Year,)
		I for the	NY	Chili	cal (E)	10~ Z	61	14	739	1	1 1	10/0	6	
1		30. Name and address of person who												
)		JOHN HYNGSTF	OM 32. Reg		U CEI	VTER	DRI	VE,	BET	HESDA,	MA.	RYLANI	2089	2
State		31. Date filed (Month_Day, Year)	J∠. 1180	al 3.311 13										

		For State Registrar		ryland / Depa		lealth and l	Mental Hygi	iene	1 100	05596
Physic		Decedent's Name (First, Middle, Las Mary Wieber Mof					2. Date of Death Month Feb.	Dey	Year 006	3. Time of Death 5:45 a
/Medi Examir		4a. Fecility Name (If not institution, give			4b. City, Town, o	r Location of Deat		4c. County		J. 45 a
		Charlestown Care	Center			tonsville			altin	
Funeral Director		363-60-4634	7. Age □M 2½2 F	(In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Dey, Dec. 8,	^{Yeer)} 1919	9. Birthp Coul	place (Stete or Foreigntry) MI
ryland how		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo						10d. Inside City Limit
the Ma	recto	MD Baltin	ore		10f. Zip Code	sville	10	Og. Citizen of \	What Cou	1 □ Yes 2]2 No
h with	ai Di	715 Maiden Choice	Lane, HV3	311	21	228		1	USA	
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or itema 23a or 28a-f show event, the Medical Exertites roust be multipled at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 🛣 No	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- to Rican, etc.)		k, White,	can Indian, etc. nite
nature	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Docup kind of work done DO NOT use retire	during most of wo	rking	dustry		
e filed within 72 hours aft al Hygiene. other than "natural", or vent, the Meulcal Exem	ошо	Elementary/Secondary (0-12)	College (1-4or 5-	+) ""6.	Sales			R	eal I	Estate
	To Be C	17. Father's Name (First, Middle, Last) Ferdinand Wieber				18. Mother's Nar Ann Sl	me <i>(First, Middle, N</i> attery	Maiden Suman	ne)	
od 2 lith a 27 ts		19a. Informant's Name/Relationship (7 John Moffat/Son	City or Town, d, MD	State, Ziji 2101						
		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐		20b. Place of Dispo cemetery, crea Metro Ci	natory or other pla	rei	h 10	20c. Location - Baltim		
permit. Pages Department of h Important: If the any injury or or		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		2 <u>2</u>	Name and Addre	& Sons	P.A. Seve	erna Pa	rk Fi	neral Hor
<i>7</i> 8		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused	the death. Do not ent			Hwy, Seve		LK, P	Approximate Interval Between
Physician /Medical pe executed be precipilated by brightness as the burial-transit	Icai Examiner	disease or condition resulting in death) Sequentially list conditions, I any, leading to ammodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	a consequence of): I RE TE LOUISA, JULY SO a consequence of):	Hyper t	ension	1			
To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	□Ectopic pregnanc □ Other (specify) _	у			te of deliv	ery Day Year
w requires that been signed b should be deta		Part II. Other significant conditions of Atria (f. bril	7	it not resulting in the u	nderlying cause giv	ven in Part I.		oacco use con es 2 □ No		the cause of death? bably 4 onknow
The law requate has been page 2 shoul	Completed by						24a. Was a autops perfor 1 \(\text{Yes} \) 2	ned?	Were autoprior to codeath?	opsy findings availat ompletion of cause o
sician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of De	ath (Check only on		100	
lysici iis cer direc	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/Outpatier	nt 3 DOA Ott	er: 4 Nursing	dome 5 ☐ Reside	ence 6 🗆 Oth	er (Speci	fy)
t or Attending Phatter death. Director: After th	Certification;	3 ☐ Suicide 6 ☐ Could not be	27. Manner of Death 1. Matural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury 4 Work? 28d. Describe how injury occurr 4 Work? M 1 Yes 2 No							
To the Hospitel or Attendwithin 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined	building, etc				City or Town	n, State)		
he Hosp n 24 hou ne Fune sletely fil	Medical			of my knowledge, deat examination and/or in ted.			urred at the time, d	ate and place,	and due	to the cause(s)
To ti withi To ti comp	W	29b. Signature and title of certifier	B 0		29c. Licens	se number	_ 2	9d. Date signe	d (Month	Dey, Year)
)		30. Name and address of person who				14377	7.4.	110		21228
St. Regist	ate	31. Date filed (Month, Day, Year) FER 0 8 20		Maiden C	hoice 1	rave, C	alone VI	110,1	MO	do

				partment of Health and Mental Hygier ertificate of Death Reg	4000 00001
			Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
	Physici: /Medic		James Floyd Murray		1, 2006 4:30 a M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Chesapeake Woods Center	Cambridge	Dorchester
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 2 13 12 5055 1 M 2 F 92 Yrs.	Months Days Hours Min. (Month, Day, Ye	9. Birthplece (State or Foreign Country)
	Director		213-12-3933	Dec. 14,1	913 Maryland
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	Mary f sho	lor	Maryland Dorchester Hurlock		1 ☐ Yes Z∰No
	the 28a	Director	10e. Street and Number	10f. Zip Code 10g.	Citizen of What Country?
	3a or		4716 Back Street	21643 U	SA
	deeth ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian,
9	after or Ite	Fur	Armed Forces? 1 □ Never Married 211 Married 1 □ Yes 2 11 No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
င္တ	be filed within 72 hours after deeth with the Maryland at Hygiene. All the William of other then "naturel", or items 23a or 28a-f show other then "naturel", or items 23a or 28a-f show event. The Medical Everall at mast be notified at	l by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No Specify:	Specify: Black
ည	72 h	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of working	b. Kind of Business/Industry
7	Athin 19.	ldμ	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	_
2	fled v flygier her ti	S	8th Fore	man Aci	me Cannery
and	be fi	Be	George Murray		den Sumame)
Maryland 21215-0036	d Me d Me nark natic	2		Vera Hopkins 	its or Tour State Zin Code
<u>N</u>	d2s than 7 Is I			Back Street, Hurlock, Mary	
စ်	Heal Heal tem 2		20a Method of Disposition 20b Place of Disp	position (Name of Date 20c	: Location - City or Town, State
on I	ages ant of it: If I		IX Younai 21 Cremation 31 Removal from State	ematory or other place) urg Cemetery 02/04/06 Hu	rlock, Maryland
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Brain niury or other traumatic event, the Medical Exercit at made to rediffied at Once.			22. Name and Address of Facility	riock, maryranu
ñ	Den Pen Pen Pen Pen Pen Pen Pen Pen Pen P		Adm A. (Xome)	Bennie Smith Funeral Home 516 South Main Street, Hur	lock, Md. 21643
			23a. Part 1 Enter the disease, or complications that caused the death. Do not en shock of heart failure. List only one cause on each line.		
	Pnysician		Immediate Cause (Final	T balance	Opset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	I'm Shirth	D1193
Н	Examiner		Sequentially list conditions b. DUSOMAS	A	DAYS
	n #	ner	if any, leading to immediate Due to (or is a consequence of):	100 / - 1/.	
	acute ind trans	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Pue to (or as a consequence of):	Myelopaing	Months
, 0	cate be executed physician and the burial-transii	E	resulting in death) Last Due to (or as a consequence of):		
8760,	cate be executed physician and the burial-transit	dlcal	d		
9 ×	ding l	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	30	Old Date of delivery
Вох	atten for u	clan	in the past 12 months?	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
o.	the d y the ched	Physician/Me	1 Yes 2 No 9 Unknown	- Cities (appearsy)	
۵.	es that the death certificing the detached for use as	y Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacc	co use contribute to the cause of death?
Records,	quires n sign	d by	Jeschemic CardiomyopaThi	1) Phomothorax 10 Yes	2 No 3 Probably 4 Homenown
00	tw require s been si	olete	Reniem Prostatic Huse	at 10 Ohn , Anomia 24a. Wasan	24b. Were autopsy findings available
	sician: The law requires that the death certificate has been signed by the attending irrector, page 2 should be detached for use as	Completed		autopsy performed	prior to completion of cause of death?
Viita	ian: rtifice stor, p	O	25. Was case referred to medical	26. Place of Death (Check only one)	1140
>	nysica lis ce direc	To B	examiner? 1 □ Yes 2 □ ER/Outpatie	ent 3 DOA Other: 4 Morsing Home 5 Residence	e 6 Other (Specify)
0	ding Phys T. After this funeral di		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury		njury occurred
Sio	eath. or: A the fu	catle	2 ☐ Accident investigation	M 1 Yes 2 No	
Division of	I or Attencafter death after death Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f. Location (Street City or Town, St	t and Number or Rural Route Number, Itate)
ш	pital		29a. Certifier Secretifying Physicien: To the best of my knowledge, dea	ath accurred at the time, date and place, and due to the cause	o(s) and manner as stated
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at the time, date	and place, and due to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	29c. License number 29d.	Date signed (Month, Day, Year)
)			I fors a fan D.O.	H-44615	2/6/06
1	2		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	
	٧		(/ Lois A NAR2 D.O.	100 Bramble 57	Cambridge MD
	Sta Registr		31. Date-Hild (Month, Day, Year) 32. Registry's Signature	Jack .	V

			1 - State Registrar	State of Marylan		artment of H			giene Reg. No.	006	05588
	q		Decedent's Name (First, Middle, Last					2. Date of Dea	th		3. Time of Death
	Physici /Medic		MARION	V MITC	HEI	LL		Februa	Day), 2006	4:43 PM
	Examin	er	4a. Facility Name (If not institution, give	e street and number)			Location of Death			ounty of Death	10000
			5. Social Security Number 6. S	ex 7. Age (In yrs.	loot hirthday	ELK If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			COUNTY
E	Funeral Director			M 2 X F 82	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	Year)		place (State or Foreign ntry) aware
	b		Usual Residence of Decedent					10-12	,-134	ZJ DET	aware
	anylar show	_	10a. State 10b. County		y, Town or Lo	cation				1	10d. Inside City Limits
	8a-1	Director	Maryland Cecil	r ET	kton						1 ☐ Yes 2X No
	a or a	٥į٢	10e. Street and Number 202 Skipjack (7+		10f. Zip Code 219	21		10g. Citize US	en of What Cou ∆	ntry?
	ns 23	by Funeral	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. 1			ecify Yes or No-		. Race - Ameri	can Indian,
9	after or Itan	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No		Was Decedent of Hi f Yes, specify Cuba		Rican, etc.)		Black, White,	
8	ural', c	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🐼 No	Specify:		S	_{Specify} Whit	
7	"natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	turing most of work.	ing	16b. Kind	d of Business/In	dustry
12	withir ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	4	s Agent	,		Real	estate	2
ğ	ould be filled within 72 hours after death with the Maryland Mental Hygiene. arkad othar than "natural", or Itams 23a or 28a-f show attle evant, the Medical Examinar must be notified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden S	umame)	
<u>lar</u>	uld be Menta rrkad rtlc ev	To B	Walter William	Harry			Anna	Clark			
Maryland 21215-0036	2 she and Is m	Ū	19a. Informant's Name/Relationship (Туре, Print)		ng Address (Street a					Code)
	1 and Health am 27 thar tr		Rita Hewitt	201-5		Skipjac				21921	
Baltimore,	Pages Inent of Hunt: If its		20a. Method of Disposition 1 Suburial 2 Cremation 3	Removal from State	emetery, crer	sition (Name of natory or other place	θ) 3 1	0ate 4 – 0 6		ation - City or T	own, State
를	permit. Pages Department of I Important: If its any njury or of		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Second Liber 			e Vetera	.11.5				> N.T
Ba	Departing Important any r		DATENTO	t more	2	2. Name and Addres	oad St.			n,DE.	
F			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	h. Do not ent	er the mode of dying	g, such as cardiac			11,03.	Approximate Interval Between
B	Pnysician		Immediate Cause (Final disease or condition	CARDIO	M40	PATH	1			2	Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq		4				1	110 7011=)
	Examiner		Sequentially list conditions,	b. CORONA		ARTER	-4 DISE	TISE			1 X YEAR
	ed sit	nlne	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence oi):						
	and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):						
8760,	icate be executed physician and s the burial-transit	dicat		. d.							
9	tificat ng phy as th	Φ.							T		
Вох	th cer tandir or use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23	d. Date of deliv	,
	e dea the at ned fo	Physiclan/M	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4☐Pregnant at time of d 9☐Unknown		Other (specify)				Month	Day Year
о. О.	uires that the death certifil signed by the attanding of d be detached for use as	Phy	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying cause give	on in Part I	23e. Did to	bacco use	a contribute to t	he cause of death?
Records,	signe d be	d by	ADRIIC STE	20515, Hy	0 1	EN SION	1	1 🗆 Y	\		bably 4 Unknown
COL	w requir been si should	Completed						24a. Was	30	24b. Were auto	posy findings available
	The fa te has age 2	dmo						autop perfor	med?	death?	opsy findings available impletion of cause of
Vital	rtifical	BeC	25. Was case referred to medical			-	26. Place of Deatl	1 ☐ Yes	2X No	1 🗆 Yes	2 XNo
>	hysici nis ce I direc	To E	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier	it 3□ DOA Othe				☐Other (Speci	(y)
2	ing P	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe h	ow injury	occurred	
Division of	ttand death tor: /	Certification;	2 Accident investigation 3 Suicide 6 Could not b	A			Yes 2 □ No	28f Logation /S	trant and	Number or Dur	al Bouta Number
$\overline{\underline{N}}$	l or A	ertif	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)	eet, ractory, office		City or Tow	n, State)	Number or Hur	al Route Number,
	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death. To tha Funaral Director: After this certificate has been signed by the attanding p completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	wledge, deatl	n occurred at the tim	ne, date and place,	and due to the o	ause(s) a	nd manner as s	stated.
	he Ho in 24 ł ha Fu oletely	Medical	(Check only 2 Medical Exer	niner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my op	pinion, death occurr	ed at the time, o	date and p	place, and due t	o the cause(s)
	Tot withi Tot	Σ	29b. Signature and title of certifier	MI.D	. ^	29c. License				signed (Month,	
			Melelin E.	Nadarax, 1	N.V.	1000	17 62	5	recy	vary 1	0,2006
	7		30. Name and address of person who	Completed cause of SU	1 23a) (Type,	Print) EL(HOR E	- 1914:14 D 2 i	GS	NG, M	ρ
	Sta	te	31. Date filed (Month, Day, Year)	32. pogistrar's Signa	IU L	nests 1	010 1101	0 01	12/		
	Danish		FEB 13 1	/DOS DESIGNA -	No M	100					

			1 - For State Registrar	State of Maryla		artment o rtificate d			2ne 2006	05589
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia		Mary	Louise	Mauti	no		February	5, 2006	11:00 PM
	/Medic Examin		4a. Facility Name (If not institution, give st.				n, or Location of D		4c. County of Death	1
			28409 Honeysuck1	e Drive		Dama	scus		Montgome	erv
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	s. last birthday)		ear If Under 24	Hrs. 8. Date of Birth Min. (Month, Day, Y	9 Birth	nplace (State or Foreign untry)
	Director		197-22-7124	M 2XIF 76	Yrs.	WIOTERS Da	lys Hours	Oct. 18,	1929 Peni	nsylvania
	pud 🛊		Usual Residence of Decedent 10a. State 10b. County	100.0	City, Town or Lo	ocation				10d. Inside City Limits
	sho	آر م			_					1 □Yes 2 ₩ No
	the N	Director	Maryland Montgomer 10e. Street and Number	У	Damasc	10f. Zip Coo		100	. Citizen of What Cou	
	with	٥		Desire				109	U.S.A.	3111 y :
	ns 23	Funeral	28409 Honeysuckle	Was Decedent Ever in	U.S. 13.	208 Was Decedent		n? (Specify Yes or No-	14. Race - Amer	rican Indian,
'n	ritar	핊	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 2 No				n? (Specify Yes or No- Puerto Rican, etc.)	Black, White	, etc.
ဗ္ဗ	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Madical Examinar must be motified at	by	3 Midowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2X	No Specify:		Specify: Wh	ite
2-0	72 hc natur	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Oc	ccupation	of working	b. Kind of Business/I	ndustry
2	ithin nan	du	Elementary/Secondary (0-12)	College (1-4or 5+)			one during most o atired)			
2	filed w Hygier other th	Cor			Home	emaker	40.14.11.1		Own Ho	me
and	be fi	Be	17. Father's Name (First, Middle, Last)					s Name (First, Middle, Ma	_	
aryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Menkantal Hygiene. Is marked to the than "natural", or Itams 23a or 28e-1 show is marked other than "natural", or Itams 23a or 28e-1 show aumatic evant, the Martical Examinating mail be notified at	T ₀	Lester Stine		105 Mail	- Address /Ch		zabeth Dou or Rural Route Number, C		in Codo)
Ma	d 2 si th an 7 is r traur		Rebecca A. Stevens	•				Drive, Damas		
	ges 1 and 2 should it of Health and Men it If Itam 27 is marka or othar traumatic		20a. Method of Disposition	- · ·	Place of Dispo	sition (Name o	f !		c. Location - City or	
ltimore,	Pages nert of I int: If Its iry or o		1 □ Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	moval from State		matory or other	metery 2	/0/06 14	annette	Pennsylvania
			21. Signature of Funeral Service License	X	~		ddress of Facility	79700	eannecte,	1 emisy ivanie
Ba	permit. Departimont import any inj		T T	100.	_/ Mo	oleswor	th-Willi	ams P.A., Fu	ineral Hom	e 20072
			23a. Part 1. Enter the disease, or complic	ations that caused the de	ath. Do not en	ter the mode of	dge Koad dying, such as ca	Damascus ardiac or respiratory arres	, Mary Land	20872 Approximate Interval Between
١.	Physician		shock, or heart failure. List only one Immediate Cause (Final	CP.O.3		ell	C7100	10000		Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conse			Carc	noma		Years
	Examiner		Consentation for an extension							
	D =	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):					
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
, 0	the death certificate be executed y the attending physician and iched for use as the burial-transit		resulting in death) Last	Due to (or as a conse	equence of):					
8760	cate b	dlcal	d.							
9 XO	eath certific attending p	Physician/Me	IF FEMALE:	c. If yes, outcome of preg	nancy				22d Date of doll	
Bo	atten for u	clan	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	ital death 3	□Ectopic pregna □ Other (specify			23d. Date of deli Month	Day Year
o.	by the stached	iysk	1 ☐ Yes 2 ☐Ño 9 ☐ Unknown	9 Unknown	dealii ot	_ O (1161 (3 <i>pecin</i>)	//			
صِّ	res that igned b		Part II. Other significant conditions conti	ributing to death but not re	esulting in the u	inderlying cause	e given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	quires n sigr	d by						1 🗆 Yes	2 □ No 3 □ Pro	obably 4 Unknown
Records,	s been should	lete						24a. Was an	24b. Were au	topsy findings available
	The law requires that ate has been signed b page 2 should be deta	ompleted						autopsy performe	death?	completion of cause of 2 No
Vital		e C	25. Was case referred to medical				26. Place o	of Death (Check only one)	1140	20110
	dir	To B	examiner? 1 Yes 2 No	spital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other: 4 Nurs	ing Home 5 esiden	ce 6 Other (Spec	city)
0	ding Ph h. After th funeral		27. Man of Death 1 ■ Natural 5 ■ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c.	Injury at Work?	28d. Describe how		
Sio	uttandin death. ctor: Al y the fu	atlc	2 Accident investigation			М	1 ☐ Yes 2 ☐ No			
Division of	I or Attano after deatl Director: I in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st cify)	reet, factory, off	fice	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	urs a							<u> </u>		
	To the Hospitel or Attanding within 24 hours after death. To tha Funaral Director: After completely filled in by the fune.	edical	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examine	cian: To the best of my keer: On the basis of examinand manner stated.	nowledge, deal nation and/or in	n occurred at tr westigation, in r	ne time, date and my opinion, death	occurred at the time, dat	ise(s) and manner as e and place, and due	to the cause(s)
	o tha o tha	Me	29b. Signature and title of certifier	and mariner stated.		29c. Lic	cense number	290	d. Date signed (Monti	h, Day, Year)
	トミトで		▶ ★) Inha	1	8	1.2014	78 F	chiral (2006
	ID		30. Name and address of person who com	pleted cause of death (It.	em 23a) (Tvpa	Print1				- 6
	10		Steven Dolinsk	a l	Rus		ve. 6	* thers burs	wg.	
	Sta	te	31. Date filed (Month, Day, Year) 0 20	32. Fisgistrar's Sig	nature	have .				
	Registr	ar	1 55 7 0 FO	Moune	1					

			State of Maryland / Department of Ho		ng nne n55	90
			1 - State Registrar Certificate of L 1. Decedent's Name (First, Middle, Last)	Death 2. Date of Death	. No. 3. Time o	n Death
	Physicia	an		Month February	Day Year	.5 A M
	/Medic Examin		Kelly St. John Morgan 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or		4c. County of Death	J A
	LXamin	C1	22 Silverwood Circle, Apt 12 Annapo	lis	Anne Arundel	
Ī	Funeral Director		5. Social Security Number 6. Sex 1XXM 2 F 46 7. Age (In yrs. last birthday) 11 Under 1 Year Months Days	Hours Min. 8. Date of Birth (Month, Day, Y	9. Birthplace (State Country) Marylan	or Foreign d
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside 0	City Limits
	oth with the Marylar 23a or 28a-f ehow	Į	Maryland Anne Arundel Annapolis			s 2 🕅 No
	r 28a	Directo	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Country?	
	th witi	al D	22 Silverwood Circle, Apt 12 21403	U	nited States	
	eep .	Funeral		spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.	
5-0036	hours after deeth with the Maryland turel; or Items 23a or 28a-f ehow al Exocal or must be collified at	by	1 Never Married 2 Married 1	Specify:	Specify: White	
12-C	22	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done difference of the DO NOT use retired)	uring most of working	b. Kind of Business/Industry	
212	d within giene. er then "	mo	Elementary/Secondary (0-12) College (1-4or 5+) Restaurant M	lanager Fo	od & Beverage I	ndus tr
	be filed ntal Hygi of other event, I	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Ma	iden Sumame)	
<u>X</u>	Menti Menti Brked atic e	To		Rae Lee		
Maryland	2 should and le m			nd Number or Rural Route Number, C		403
	s 1 and f Heelth Item 27 other tr		James H. Morgan II / Father 22 Silverwood 20a. Method of Disposition (Name of	Circle, Apt 12 A	c. Location - City or Town, State	403
altimore,	00= 5		1 \$\overline{\pi}\$ Burial 2 □ Cremation 3 □ Removal from State	9)		-
	mit. Pag pertment sortant: Injury o		4 ☐ Donation 5 ☐ Other (Specify) Cedar Bluff Cemete 21. Signature of Funeral Service Licensee 22. Name and Address	ery 02/09/2006 A sol Facility John M. Tay		
Ba	Depermine Deperm		100 1 0	of Gloucester St.		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying		t. Approxima	ate
	Physician		snock, or near failure. List only one cause on each line.		Occasional Be	Death
'	/Medical		Immediate Cause (Final disease or condition resulting in death) a. Severe Lytumb Due to (or as a consequence of): Lymbo Course	rulen aystu	ruch) 2m	uru s
	Examiner		typuleus ine ca	rdionyopat	in 10 y	ears
	D =	ner	cause. Enter Underlying		20	
	ecute and trans	Examiner	that initiated events c.		40	year
60,	ate be executed hysiclen and the burial-transit	Ē	Due to (or as a consequence of):			•
09/8	icate t physic s the t	dical	d			
×	death certificate e attending phys id for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	
ROX	atten atten I for u	clan	in the past 12 months?		Month Day	Year
o.	at the de by the a tached	lys	1 Yes 2 No 9 Unknown 9 Unknown			
 J	law requires that the as been signed by th 2 should be detache	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	n in Part f. 23e. Did toba	cco use contribute to the cause of	death?
Ĕ	w require been sig should b	edr	END Shope Manin Visionse	1 🗆 Yes	2 No 3 Probably 4]Unknown
ecords,	aw re	Completed	Hemodroys, S	24a. Was an	24b. Were autopsy linding:	s available
ř	0 - 0	ΕÓ	Clunic Atrial Fibility	autopsy performe	prior to completion of death?	Cause of
Vital	Attending Physician: Th r death. ector: After this certificete by the funeral director, pag	Be (25. Was case referred to medical examiner?	26. Place of Death (Check only one)	7	
	Physic this c	မှ	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	4 Indising Home 5 Hesiden		
ב	ding P h. After funera	lon:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury Work		injury occurred	
<u> </u>	ttendi death. ctor: A y the fu	cat	3 Suicide 6 Could not be 280 Blood of Injury At home form street fortice.	/es 2 □ No	et and Number or Rural Route Nu	mbas
Division of	al or A sefter I Direct d in by	Certification:	4 Homicide determined building, etc. (Specify)	City or Town,	State)	11007,
	To the Hospital or Attendi within 24 hours effer death. To the Funaral Director: A completely filled in by the fu		29a. Certifier (Check only (Check only 1) Medical Examiner: On the basis of examination and/or investigation, in my open	e, date and place, and due to the cau	e and place, and due to the cause	(s)
	within 2 within 2 To the 7 complete	Medical	one) and manner stated.			
	N N N		10 6		1. Date signed (Month, Day, Year)	
				8314		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1,8vite400 Ann	apolis MD	21401
	Sta	te	George Samaras, M.D. 116 Describe thighway 31. Date filed (Month, Day, Year) SER 0.9 2006	1,8vite400 Ann	apolis MD.	21401

06-00807 B.K.S THOMAS S. MORGAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

of Maryland / Department of Health and N	Mental Hygiene 006 0559	
Certificate of Death	Bed No	

			T - For State Registrar	Otate of Mai		rtificate of			Reg. No.	6	CCU	91	
			1. Decedent's Name (First, Middle, Last)					2. Date of De Month	eath Day	Year	3. Time of	Death	
	Physici /Medio		Thomas Stevenson	Morgan				FEB.	1, 2006	5	1951	РМ	
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Deat	th	4c. County				
		191	ST.MARY'S HOSPITA			LEONARD			ST.M				
	Funeral		5. Social Security Number 6. Sex	M 2DF	In yrs. last birthday, Yrs.	Months Days	If Under 24 Hrs Hours Min		th ay, Year)	9. Birthp Cour	place (State o	r Foreign	
	Director		216-70-9663 Usual Residence of Decedent	4	3 Yrs.			March 18	3, 1962	Mary	1and		
3	M m		10a. State 10b. County	1	0c. City, Town or L	ocation				1	Od. Inside Cit	ty Limits	
	E P	ğ	Maryland St. Mary	18	Great	t Mills					1 🗌 Yes	X□ No	
4	1288	rec	10e. Street and Number		Orda	10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?		
1	23a o	a D	45888 Chancellors	Run Apts #	1101	20634			USA				
0000	s Tarlot Stitutus be lifed within 12 floors eller beaut with the maryland. Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or itams 23e or 28e-f show other traumatic event, the Modical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Mever Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Blac	e - Americ ck, White, Blac			
200	en "natur Madical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	edent's Usual Dccup e kind of work done DO NOT use retired	during most of wo	orking	16b. Kind of Bu	ısiness/ln	dustry	-	
7	th the	io.	10	- 3. ,		Chef			Restra				
	d oth	Be (17. Father's Name (First, Middle, Last)						, Maiden Sumam	10)			
<u> </u>	and Mental and Mental amarked c	၉	Thomas Morgan					es Whela					
• .	Is m		19a. Informant's Name/Relationship (Ty)			ing Address (Street				State, Zip	Code)		
, b	16alth 16alth 1m 27 i	1 8	Eric Morgan / Bro 20a. Method of Disposition	ther	the second secon	Golden R		Lusby MD	2065 / 20c. Location -	Cibr or To	oum State		
2	or of the		1 XBurial 2 ☐ Cremation 3 ☐ R	emoval from State		osition (Name of ematory or other place				•			
	rtant		4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur® of Funeral Service License			S U.A.M.E.		8, 2006	Valley	Lee,	MD		
ם פ	perimit. rages I am Department of Heali Important: if itsm 2 any injury or other once.		to be of	4-1	()_ '	Matting	ley-Gardin	er Funeral	Home, P.	Α.			
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only on	cations that caused	e death. Do not en		x 270, Leo ng, such as cardia				Approximate Interval Bets	е	
	hysician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate		consequence of):	Tuzu	ues)				Onset and [Death	
recolds, r.O. Box 08760,	physicien and s the burial-transit	Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.										
O YOU O.	been signed by the ettending p should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	y			23d. Date of delivery Month Day Year			
r (spins)	on signed to	Ď	Part II. Other significant conditions con	tributing to death but	not resulting in the t	underlying cause giv	ven in Part I.		tobacco use cont Yes 2,∕€No		he cause of d bably 4 □L		
itai neco	s certificate hes bee lirector, page 2 sho	Completed						24a. Was auto perfe 1≱ Yes	psy ormed?	Were auto prior to co death? 123 Yes	opsy findings impletion of ca 2 No	available ause of	
X	certif	Be	25. Was case referred to medical examiner?	ospital:	o 83	Oth	0.00	ath Check only					
5	r this	To	11√2 Yes 2 No '' 27. Manner of Death	1 Inpatient 28a. Date of Injury	2 X ER/Outpatie	AIL 30 DOX	4 Indising	28d. Describe	how/injury occur	red / a	an-w	dient	
5	fung fr	ţ	1 ☐ Natural 5 ☐ Pending Accident investigation	(Month, Day')	(ear) Injury	> Wor	rk? Yes 2 ⊠No	Deceas	od pede	STAN	at be in	object.	
	r dea rctor	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, farm, si	treet, factory, office		29f Location	Street and Numb	er or Run	Al Route Num	ber, L	
5	s efte	Certification	4 ☐ Homicide determined	building, etc.	STILL	t		nulls Ro	wn, State) R+	246	MDSLIII	eax	
1	The first properties of animoning ray sevent. The within 24 hours effect death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical (29a. Certifier (Cneck only one) 1 Certifying Physical Examination Medical Examination (Cneck only one)	ician: To the best of lest. On the basis of ea and manner state	xamination and/or if	th occurred at the tir nvestigation, in my o	me, date and plac opinion, death occ	a and due to the	onuco(c) and ma	20001 00 0	tatod	Ø.	
,	To #	M	29b. Signature and Ale of Certifier	nM	1	29c. Licens	ce number		FEB. 3				
			30. Name and address of person who co	mpikud cause of dea		, Print) NN STREET	, BALTIMO	ORE, MARY	LAND 212	201			

State Registrar

			for State Registrar		State of Ma	aryland	-	artment tificate			nd M		Reg.	LUL	16	05592
	Physici /Medic		Decedent's Name (First, Middle		s Gertru	de Me	yer					2. Date of Month Febru		Day 4, 2	006	3. Time of Death 10:20 AM
	Examin	er	4a. Facility Name (If not institution	n, give st	reet and number)			4b. City,	Town, or	Location of	Death				ity of Death	
			St. Marys Nurs 5. Social Security Number	ing 6. Sex		/In use i	ast birthday)		nard	town If Under 2	4 Hrs	9 Data of	Diah		Marys	(2)
	Funeral Director		578-14-5654		M 2∑F	9:	* * * * * * * * * * * * * * * * * * * *	Months	Days	Hours	Min.	8. Date of (Month) June	Day, Y.	ear)	Mary	
1	D		Usual Residence of Decedent						I			June	2,,,,			
	ehow	7	10a. State 10b. County			•	, Town or Lo								1	0d. Inside City Limits 1 ☐ Yes 2XXNo
	28a-f	Directo	Maryland St. M	ary'	S	Н	ollywo	od 10f. Zip	Codo				100	Citizon	f What Cour	
	with 3a or		44987 Nalley R	oad					636				109			iti y :
	death me 23	Funerai	11. Marital Status		2. Was Decedent B	Ever in U.	S. 13.	Was Deced	lent of His	spanic Origi	in? (Spe	cify Yes o	No-		ace - Americ	
21215-0036	should be filed within 72 hours after death with the Maryland Montal Hygiene. marked other then "natural", or lieme 23e or 28e-f ehow imatic event. It a Medical Examinal mari be notified at	by	1 ☐ Never Married 2 ☐ Marri 3 ※ Widowed 4 ☐ Divorced		Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:	lo	i	1 Yes, spec 1 ☐ Yes		Specify:	Puerto i	Rican, etc.)	Spec	lack, White, cify: Whi	
5-0	72 ho	Completed	15. Deceden				16a. Dece	dent's Usua	il Occupa	ition uring most	of workir	na	16	b. Kind of	Business/In	
2	ne. hen a	mpi	Elementary/Secondary (0-12)		College (1-4or 5	+)	life.	DO NOT us	e retired))		.9				
2	filed v Hygie other t	S	17. Father's Name (First, Middle,	l ast)		- 1	Stock	Cler	K	18. Mother	's Name	/First Mid			ent Sto	ore
Maryland	ould be f Mental I arked of atic eve	o Be	Joseph King Da												ame)	
Z	shoul nd Me mark imark	10	19a. Informant's Name/Relations		e, Print)		19b. Mailir	ng Address	(Street a			ell I I Route Nu			m, State, Zip	Code)
Š	aith a		Debra L. Dixon	/ N	liece		44987	Nalley	Road	Holly	wood.	Mary	land	20636		
Baltimore,	pe rrit. Peges 1 and 2 should be Depriment of Health and Monta Im crtant: if item 27 is marked en injury or other treumatic e 20 a.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		moval from State	Ce	ace of Dispo emetery, crer : Lincol	sition (Nan	ne of	1	D	ate cuary	20	c. Location	n - City or To	
Balti	pe nit. Dep rtr Imcorte en inju		21. Signature of Funeral Service,	License	He down	0	22 Ma	. Name an atting!	ley-Ga	s of Facility ardiner Leona	Fune	eral He	ome,	P.A.		, 23.1.4
-7			23a. Part1. Enter the disease, or shock, or heart failure. List	complic	ations that caused	the death									50	Approximate Interval Between
E	Pnysician		Immediate Cause (Final disease or condition	Only One	X Cause on each	610	DA	los.	11	zal	40	d	_			Onset and Death
	/Medical Examiner		resulting in death)	("	Due to (or as	cons qu	uence off)	Y	1	7/1	(1)					
1	LXummer	<u>_</u>	Sequentially list conditions,	b.	Due to (or a	consequ	race	me	Me	zen	Y					
	nsit	nine	cause. Enter Underlying Cause (Disease or injury	<	Due to tol as	Pari	es alla la	n//	2/67	OPI	41	À.				
Ć.	icate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last	C.	Due to (or as	a consequ	ience of	75	1	04	سك	4				
8760,	ite be iysicie ne bur	dicai		d.			(_)								
9		(L)	IF FEMALE:	-									_		-	
Вох	death certific e attending p id for use as I	Physician/M	23b. Was decedent pregnant in the past 12 months?	23	ic. If yes, outcome	2 Fetal	death 3[Ectopic pr							Date of deliv Month	ery Day Year
o O	0 0 0	ysic	1 ☐ Yes 2 個 No 9 ☐ Unknown		4☐ Pregnant at 9☐ Unknown	time of de	eath 5	Other (sp	ecify)				-			
٣.	res that I signed by be deta		Part II. Other significant condition	ons cont	inbuting to death bi	ut not resu	ılting in the u	nderlying c	ause give	n in Part I.		23e. [Did toba	cco use co	ontribute to t	he cause of death?
rds,	quires in sign	ed by										1	☐ Yes	2 No	3 🗌 Prol	bably 4 Unknown
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Vital	sician: Th certificate irector, pag	Bec	25. Was case referred to medica examiner?	1						26. Place	of Death	,				
5	Physic this can dire	၉	1 ☐ Yes 2 Ø No	Н			ER/Outpatier			4 (2 Null					Other (Special	(y)
Division of	ding F h. After funera	ion:	27. Manner of Death 1 Natural 5 □ Pendir		28a. Date of Injui (Month, Da)	Year)	28b. Time o Injury	f 2	8c. Injury Work			28d. Desci	ibe how	injury occ	curred	
isic	Attending Physician: ar death. rector: After this certific by the funeral director,	ficat	2 Accident investi	not be	28e. Place of Inju	urv - At ho	me. farm. sti			res 2 □ N		281. Locati	on (Stre	et and Nu	mber or Run	al Route Number.
2		Certification:	4 Homicide determ	iiiieu	building, etc	c. (Specify	')	,,	,				Town,			
	To the Hospitel or Attenwithin 24 hours after deati To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physi Examin	icien: To the best of er: On the basis of and mariner sta	of my kno examinat	wledge, deat tion and/or in	h occurred vestigation	at the tim	e, date and pinion, death	place, a	and due to ed at the ti	the cau	se(s) and and plac	manner as s e, and due t	stated. o the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifie		DII	1)	11/		. License		110	<u> </u>			ned (Month,	
)) Ha	me	A las	105	5VI	7		00	41	1		1-	-6-6	8
			30. Name and address of person	who cor	npleted dause of d	eath (Item	23а) (Туре,	Print)			- 1					
			James P. Jarboe,		24035 Thr	1. 0:			ywood	l, Mary	land	20636				
100 m	Sta Registi		31. Date filed (Month, Qal, Year)	2006		ar's Signa	ture	de								

		1	For State Registrar	State of Maryland		artment <i>tificate</i>			and M		giene ()	06	05593
			Negistrar Necedent's Name (First, Middle, Last)						2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia	in	CAROLYN JORDA							FEBRUA		2006	9:15 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, T						nty of Death	
			26460 MORGANZA TU					CSVI		B. Coto of Bird		MARY	
	Funeral		5. Social Security Number 6. Se	TH OF E	st birthday) Yrs.	If Under 1 Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Day	7, Year) 1947	Coul	place (State or Foreign ontry) TH CAROLINA
	Director	-	219-48-0079 Usual Residence of Decedent	58						OCT. 5,	1947	NOK	IN CAROLINA
	tand	-	10a. State 10b. County	10c. City,	Town or Lo	cation							10d. Inside City Limits
	Mary	ţ	MD ST. MARY	'S MECH	ANICS	VILLE							1 ☐ Yes 2 X ☐ X No
	h the	Director	10e. Street and Number			10f. Zip (Code				10g. Citizen		ntry?
	th wit	aiD	26460 MORGANZA TU				659			N		S. A.	ann Indian
	eme.	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13.	Was Decede If Yes, speci	ent of Hi ify Cubai	spanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	14.	Black, White	
36	or it	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 24 (TNO If Yes, Give Year or Dates:		1 ☐ Yes 2	∑ No	Specify:			Spe	ocify:	ITE
Ş	be tiled within 72 hours after deeth with the Maryland stal Hygiene. ad other than "natural", or items 23a or 28s-f show ad other than "natural", or items awant, the Maulical Examiner must be notified at	ed to	15. Decedent's Ed	-	16a. Dece	dent's Usua	Occupa	tion	A - 6 whe		16b. Kind o	f Business/li	
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<u>la</u>	should be nd Menta marked umatic av	은	OSCAR ROYCE JORDA				(0)			ZABETH al Route Numb			in Code
Maryland 21215-0036	2 2 2 3		19a. Informant's Name/Relationship (TCHRISTINE M. WOOI		196. Maili	ing Address () M()R()	Street a	ana Numb A TIIF	er or Aur. RNER	RD. MEC	CHANICS	SVILLE	, MD 20659
	Heelth tem 27 other tr		20a. Method of Disposition	20h PI	ace of Disp	osition (Nan	ne of			Date		ion - City or T	
Baltimore,	Pages nent of H int: if Itu		1 ☐ Burial 2 ☑ Cremation 3 ☐	Hemoval from State	metery, cre NCFTF1	matory or of	ther plac IOLS	CR	FEB.	11.2006	CHAF	RLOTTE	HALL, MD
臣	it. Propriet		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		2	2. Name an	d Addres	s of Facil	BRI	NSFIELD	-ECHOI	S FUN	L.HME.,P.A.
Ba	permit. Pages Department of I Important: if Its any injury or o		Hount Bet	MOO	641 30	0195 T	HRE	TON E	CH R	D. CHAR	LOTTE	HALL,	MD 20622
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	pe #s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	Jence oi):								
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687	flicete physics physics the			<u>u.</u>									
Вох	anding use	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		□Ectopic p	regnancy	,			230	Date of del	ivery Day Year
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of d		Other (sp	pecify) _					171011111	22,
P.0	that the death red by the etter detached for u	Physician/Med	9 Unknown Part II. Other significant conditions		ulting in the	underhing	ausa div	en in Part	rl	23e. Did	tobacco use	contribute to	the cause of death?
	signed to det	Ď	Part II. Other significant conditions of	outhoring to death out not res	uning in the	underlying c	acco g	or are are		1 12	Yes 2 1	No 3□Pr	obably 4 Unknown
Records,	w requir been si should	Completed						-		24a. Wa	s an	24b. Were au	itopsy findings available
Sec.	hes t	ğ								auto	opsy omed?	prior to death?	completion of cause of
	n: The licete he r, page		25. Was case referred to medical					26 Pla	ce of Dea	1 ☐ Yes th (Check only	20 No	1 🗆 Yes	WE NO
Vital	Physician: The la rthis certificete hes ral director, page 2	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpati	ent 3□ Do	OA Ott	nor	Nursing H	-/	idence 6[□Other (Spe	cify)
of	Phy ar this eral d	7. 10.	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of	28c. Inju Wo	ry at		28d. escribe	how injury	occurred	
<u>.</u>	ittending P death. ctor: After i	atio	1 Natural 5 Pending 2 Accident investigation	n	,,	М		Yes 2	□No				
Division	ar der racto by th	Certification:	3 Suicide 6 Could not 8		ome, farm. :	street, factor	y, office				(Street and I own, State)	Number or R	ural Route Number,
Ö	ital or rs eft rai Di										e en melos es		2 Mary
7	To the Hospital or Attend within 24 hours efter death To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, de ation and/or	ath occurred investigation	at the ti	me, cate opinion, d	eath occu	rred at the time	a, date and p	lace, and du	e to the cause(s)
	thin 2 the of the	Med	29b. Signature and title of certifier	and marklet states.		29	c. Licen	se numbe	er		29d. Date	signed (Mor)	n, Day, Year)
	F ₹ F 8						70	175	386	\mathcal{I}	21	18/0	56
			30. Name and address of person who	completed cause of death (lie	m 23a) (Typ	e, Print)		-			1		
			CIND-	1 R-1	どのい	7/	m,						
	S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature								

State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) Physician 12.50 AM FEBRUARY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S CRESCENT CITIES CENTER RIVERDALE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1924 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖺 F 81 Yrs. 415-36-2105 MISSISSIPPI Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 27 is marked other than "naturel", or items 23s or 28a-f show traumatic event, the Masteal Examinatments be mailfied at 1X Yes 2 No PRINCE GEORGE'S RIVERDALE Direct 10g. Citizen of What Country? 10f. Zip Code with 4409 EAST WEST HIGHWAY # 215 20737 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel, or iten eny injury or other fraumatic event, the Modical Examinations. Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ BLACK 3 XWidowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 12th NURSING ASSISTANT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HARRIS REYNOLDS AGRIPPA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15405 LAURELTON DRIVE LAUREL, MARYLAND DANNY MOTT/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 2/10/2006 MARYLAND NATIONAL LAUREL, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ARTEMOSCIETURE CANDIO MASULAR DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) _ detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No 24a. Was an autopsy newa of aboutin Distease 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 ANatural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0185 EENSBURY ROLHYGITBUILLE MD 2021 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEVUNE 1413420 31. Date filed (Month, Day, Year) State Registrar FFR 0 9 2006

			State of Maryland / Department of Heal 1- State State Certificate of Deal		2	1006	15595
	Physicia		1. Decedent's Name (First, Middle, Last)	2	Reg. No. 2. Date of Death	ay Year	3. Time of Death
	Physicia /Medid	al	Kobin moses 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Local		February	6 2064 C. County of Death	815AM
	Examin	er	ST. Thomas more, Hyatts	ville		P.G.	County
	Funeral Director			ours Min.	B. Date of Birth (Month, Day, Year NOV 16, 19	9. Birthp Coun	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				0d. Inside City Limits
	e Mary	ctor	MD Prince Georges Hyattsville				1 Yes 2 No
	after death with the Marylan or Itams 23e or 28e-f show uner out be notified at	Funeral Director	10e. Street and Number 4927. La Salle. Road 20	783	10g. C	itizen of What Coun	try?
	tams 2	unera	11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispan		ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	
5-0036	hours after death with the Maryland tural; or Itams 23s or 28s-f show at Examiner oust be multibut at	þ	1 Never Married 2 Married 1 Yes 2 No If Yes, specify Cuban, Me 1 Yes 2 No If Yes 2 No Specify Cuban, Me 1 Yes 2 No Specify Cuban, Me	pecify:		Specify: 13	ack
15-0	n 72	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	g most of working	16b.	Kind of Business/Ind	
2121	ed within ygiene. ner than et. Ine Man	Com	College (1-4or 5+) N/A N/A			NIA	•
Maryland	uld be file fental Hyg rkad othe tic avant,	To Be	17. Father's Name (First, Middle, Last)	Mother's Name (First, Middle, Maide	n Sumame)	
Mary	s 1 and 2 should f Health and Mer itam 27 is marks other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N				
-	es 1 and of Healt fitam 2 r other		Bettie R. Gibbs / Guardian 417-12th St. S. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Da		_coation - City or To	
altimore,	t. Pag rtment rtant: f		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Riverdale Park	2/10	2006	Riverda	le MD
Ba	Departing Permi Pe		21. Signature of Juneral Service Dicense 22. Name and Address of JOHN 7. Art 30/5-/24	4970ES	VE W	45/+ D C	20017
r			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.	ich as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) ### Due to (or as a consequence of):	y VIRU	SIA	102	years
ı	Examiner	-	Sequentially list conditions, if any, leading to develope a consequence of): Due to (or as a consequence of):		_		
	cuted nd transit	Examiner	Cause (Disease or injury that initiated events c.				
8760,	cate be executed physician and the burial-transit	cal Ex	resulting in death) Last Due to (or as a consequence of):				
9	th certificate lending phy or trse as the	ed	IF FEMALE:				
Вох	e e	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23d. Date of delive Month	ry Day Year
Ö.	t the by the tache	Physi	9 ☐ Unknown	P-41	22a Did tabasas	use contribute to the	a gauge of death?
rds,	quires than signed ald be del	d by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	ranti.	1 Yes		ably 4 Unknown
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tal B	Ti ate	Be Cor	25. Was case referred to medical	Place of Death	performed?	death?	2 No
of Vi	ding Physician: n. After this certific funeral director,	2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4	Nursing Hom	e 5 Residence		1)
ion	nding P ith: : After I	ation:	27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 ☐ Yes		3d. Describe how inj	ury occurred	
Division	al or Attending F s after death. I Diractor: After d in by the funera	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	3f. Location (Street a		l Route Number,
	e Hospital or 24 hours afte e Funaral Dir etely filled in		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, do	ate and place, ar	nd due to the cause(s) and manner as s	ated.
	To the Hospital or Al within 24 hours after or To the Funaral Dirac completely filled in by	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion and manner stated. 29b. Signature and title of certifier 29c. License num			nd place, and due to rate signed (Month,	
)	F 3 F 8						
-	20	7	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PM A DEVURE MA 1723 Chreeke	L	Sof Elici	+ + + 111	MA 2020
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	الماليل الم	سر احرام	W ZUIN	100 0101
A.	Registr	ar *	FEB 1 0 2005 Februar & Sparker				

the Maryland

Baltimore, Maryland 21215-0036

28a-f ehow

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** February 06, 2006 2:14 Рм Monroy Abel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3117 Maygreen Avenue Forestville Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X**] M 2□ F 31 none Yrs. Director 1/22/1975 Guatemala Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hyglene. Important: if Item 27 is marked other then "netural", or Iteme 23e or 28e-f ehov eny injury ogogher traumatic event, If a Medical Examination in cliffed at Prince George's Hyattsville MD 1 ☐Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20785 Guatemala 14204 Langley Way Apt 1 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Never Married 2 Married 1 X Yes 2 □ No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Guatemalan Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction worker Contracting 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Santos Suchite Virgilio Monroy Rivera 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co $\overline{\it 2e}0785$ 19a. Informant's Name/Relationship (Type, Print) 14204 Langley Way Apt.1 Hyattsville, Md Mario Pedia/Brother-in-law Ortother ! 20b. Place of Disposition (Name of cemetery, crematory or other pla Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation, 5 ☐ Other (Specify) Morales, Isabal, 2/14/06 Guatemala Morales 21. Signature Fineral Service Cir nsep / PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Shotzun Physician torso wond /Medical Due to (or *s a consequence of) Examiner Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se's consequence of) Examiner ettending physicien and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 XYes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Zother (Specify) at Scene ٩ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending Injury subject was shot after death.
Director: Af 1 ☐ Yes 2 No 2-6-06 investigation 14:00 2 Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3117 May green Ave 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by construction site within 24 hours a To the Funerei MD Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

or Attending Physician: The law requires that the death certificate be executed

this

After

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) FEB 09 2006 Registrar

29b. Signature and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

February 07, 2006

29c. License number

O.C.M.E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 5,2006 2050 M FRANK FEBRUARY MILLER 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death DLNEY MONTGOMERY GENERAL HOSPIDAL MONTGOMER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1 ★M 2 ☐ F 94 579-20-2339 Yrs. JANUARY 14, 1912 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND MONTGOMERY SILVER SPRING 1X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15101 INTERLACHEN DRIVE #703 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Xi Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No WHITE Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WHOLESALE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) BERTHA ROSENTHAL NATHAN MILLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15101 INTERLACHEN DRIVE #703, SILVER SPRING, MD 20906 PEARLE MILLER-WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ₽ Burial 2 ☐ Cremation 3 ☐ Removal from State JUDEAN MEMORIAL GDNS 02/07/2006 OLNEY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S EDWARD SAGEL FUNERAL DIRECTION, 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA < ZWBEKS disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 5 ☐ Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown

Pnysician /Medical Examiner

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24 hours after death. • Funerel Director: A

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The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or Items 23a or 28e-1 show any pluy or other treumatic event, the Medical Exact its entrust by motified at once.

Baltimore, Maryland 21215-0036

the Maryland

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

24a. Was an autopsy performed? res 20 No

1 Yes

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28c. Injury at Work? 28b. Time of

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

27. Manner of Death 1 Natural 2 Accident 3 🗌 Suicide

4 - Homicide

5 Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

CL HOSPITALIST

29c. License number 162656

29d. Date signed (Month, Day, Year) FEBRUARY 6, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SONIAHOLMES, M.D. 18101 PRINCEPHILP DRIVE, OLNEY, MD 20832

Registrar

31. Date filed (Month, Day, Year) FEB 0 9 2006



			1 - For State Registrar	State of Maryla		artment of F		nd Mental Hy	giene	5 05598
	Physici	an	1. Decedent's Name (First, Middle, Last)	11 F20				2. Date of De Month	Day	3. Time of Death
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`	Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 2	24 Hrs. 8. Date of Bi	rth	9. Birthplace (State or Foreign
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ary	should nd Men marke umatic	-	19a. Informant's Name/Relationship (Type		19b. Mailie	ng Address (Street	and Number	r or Rural Route Numb	per, City or Town, S	State, Zip Code)
	and 2 selth a n 27 is		Vivian Mumford/Wife		407 H	Beaglin P	ark Dı	c. Salisbu	ry,Maryla	and 21804
Jre,	as 1 a		20a. Method of Disposition		b. Place of Dispo	sition (Name of matory or other place	ce)	Date	20c. Location - 0	City or Town, State
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89	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit		IF FEMALE:							
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	e dea the at	Physician/Med	1 Yes 2 No	4 Pregnant at time of 9 Unknown	of death 5	Other (specify)			Mon	nth Day Year
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	28		Name and a press of person who	W) Cod	тет 23a) (Туре, / Досл	Print)	32123	33 Sel	14 MD	21802
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1445P M **GENEVIEVE** MESSICK 2006 February /Medical 4a. Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicemuco Keninsula Cener working If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1□ M 2 🛂 F Days 61 JUNE 15, 1944 Director 176-34-6554 PENNSYLVANIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "neturel, or items 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No Director WICOMICO MARYLAND SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 TIMES SQUARE 21801 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Completed by 3 Widowed 4 □ Divorced Baltimore, Maryland 21215-0 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mentel Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOMEMAKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 DOMINIC CASERTA HELEN McCANN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Heelth : ANDREW MESSICK / SON 27113 MARTINS FARM ROAD, MILTON, DE 19960 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
eny injury or ot ST.PETERS CEMETERY 02/14/2006 4 ☐ Donation 5 ☐ Other (Specify) LEWES, DELAWARE M00886 PARSELL FUNERAL HOMES & CREMATORIUM 16961 KINGS HIGHWAY, LEWES, DE 19958 ell 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner ENALFAILURI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ng physicien and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical ettending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete 1 ☐ Yes 2 ☐ No 1 Yes 212 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 🗌 Yes 2 ER/Outpatient 3□ DOA this s after death. ii Director: After this od in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred Certification: Division or Attending 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 T Homicide To the Hospitel completely filled 1 Certifying Physician: To the hest of my knowledge, death concurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 063433 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SLUTE 504B, SAUSBURY, MD 2; 804 106 MILFORD ST DOSH 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H rtificate of I			giene 0 0 6	05600
	Dhyciai	4	1. Decedent's Name (First, Middle,	Last)				2. Date of Dea Month	ith Day Year	3. Time of Death
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	Funeral Director		5. Social Security Number 178-07-2141	. Sex 1	e (In yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.			hplace (State or Foreign untry) ISYLVANTA
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-	s 1 and if Health itam 27 other tr		20a. Method of Disposition	AUGHTER	20b. Place of Disp	RNING GLOI	RY WAY S	Date	DY, NY 123 20c. Location - City or	
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Baltimore	permit. Par Department Important: any injury once.		 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice 			Name and Addres		10,00		AIN STREET
Ba	permit. I Departm Importat any inju		Han M	South		OWERS FUNI		E, P.A.	FROSTBURG	
8760, <	Physician /Medical Examiner the pringl-transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	a consequence of): a consequence of):	age Ol	ostruc.	hve L	ung Disca	Onset and Death PE 5 Years
O. Box 6	death certific e attending p id for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetel death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
Records, P.	iaw requires that the de as been signed by the a 2 should be detached f	þý	Part II. Other significant conditions	s contributing to death t	out not resulting in the t	underlying cause give	en in Part I.	23e. Did to	obacco use contribute to res 2 □ No 3 □ Pr	o the cause of death?
Sor	w requir been si should	lete	Character	P	0 20:0	0		24a. Was	an 24h Were ai	itonsy findings available
I Re	The ate has page	Completed	0 8	les pours	s in	un —		autop perfo	rmed? death?	Itopsy findings available completion of cause of 2 No
Vital	cian: ertific actor,	Be (25. Was case referred to medical examiner?	1				ath (Check only o		
of	Physician: this certific ral director,	ဥ	1 □ Yes 2 No	Hospital: 1 Inpati	and the second second		4 po ivursing i		dence 6 Other (Spe	cify)
п	ding F h. After funera	lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ury 28b. Time of Injury	Worl		28d. Describe i	now injury occurred	
Sic	Attanding r death. actor: After by the funer	icat	2 Accident investigat 3 Suicide 6 Could no	t be Inc. Place of le	ium. At home form of		Yes 2 □ No	20f Location (6	Street and Number or Re	im/ Paula Number
Division	or Al after of Dirac in by	Certification;	4 Homicide determin	ed 286. Place of in building, e	jury - At home, farm, st lc. (Specify)	reet, factory, office		City or Tox		arar Abute rumber,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 2 Medical Ex	Physician: To the best eminer: On the basis of and manner st	of examination and/or in	th occurred at the tin	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	To the within 2 To tha comple	Me	29b. Signature and title of certifier	07 (`	29c. License	e number		29d. Date signed (Mont	h, Dey, Year)
	- > - 0			9 CT	andle	NO D	1446	4	2-16-	2006
•	4		30. Name and address of person with S. L. SANDHIR				BURG, M	D 21532		
	Sta Regista		31. Date filed (Month, Day, Year)		rar's Signature	and I				,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Feb 17, 2006 9:15am Metz 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Allegany Cumberland Nursing Home Cumberland If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Months 1**√** M 2□ F Jun 10. 90 214-07-6851 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Allegany Cumberland 1 Xes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21502 USA 623 Hayden Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1. ☐ Yes 2 ☐ No IYes, Give Year or Dates: \\A\\A\/II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 □Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) Celanese Corp. 12 laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harriet (Hoopengardner) Metz Lewis Wesley Metz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21502 614 White Avenue Cumberland Douglas Metz son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Memorial Gardens MD 2/20/2006 LaVale * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service Licensee 108 Virginia Avenue; Cumberland, MD 21502 23a. Politi Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, encet, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronan 10 VV) disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a State

MD

Funeral

Director

or 28e-f show

238

Director

Funeral

þ

Completed

Be

2

or other treumetic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiana. Important: If item 27 is marked other then "naturel", or Items 23s any injury or other treumetic event, If a Maded Learner const

Baltimore, Maryland 21215-0036

with the Maryland

use as the burial-transit attending physician The law requires that the death certificate be the Hospitel or Attending Physicien: fillad in by the funeral after death.

Examine Physiclan/Medlcal þ Completed Be 25. Was case referred to medical examiner? ٥ 27. Manner of Death Certification:

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

1 Yes 2 No

1- Natural

2 Accident

4 Homicide

3 Suicide

24a. Was an autopsy performed? 1 ☐ Yes 2 D No

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 2 No 1 Tyes

Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examination. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier-

29c. License number NOU 33280 29d. Date signed (Month, Day, Year) 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day Year)

Sunil Gupta, M.D.

32. Registrar's Signature 625 Kent Avenue Cumberland MD 21502

FEB 2 4 2006

5 Pending investigation

6 Could not be determined

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

State Registrar

Division of Vital Records, P.O.

Box 68760,

within 24 hours a To the Funerel L

OI	200		For State Registrar	State of Maryla		artment of F			giene	05602
	Physici	an	1. Decedent's Name (First, Middle, La	,				2. Date of Dea Month	ath Day Y	3. Time of Death
	/Medic	al			McKenzi		r Location of Deat	Februa	ry 16, 20	006 1:00 p. M
	Examin	ier	4a. Facility Name (If not institution, given 14713 McMullan H			Cresapt			Ällegar	ny County
	Funeral Director		210-34-4300	Sex 1 ☑ M 2 ☐ F 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth Month, Day Jun 8,	1934	Birthplace (State or Foreign Countor) MD
	land w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mary F-1 sh	tor	MD Allega	ny	Cres	aptown				1 Yes 2 No
	or 28	Funeral Director	10e. Street and Number	1:1	· · · · · · · · · · · · · · · · · · ·	10f. Zip Code	04500		10g. Citizen of Wh	•
	eath v	erai	14713 McMullen I	12. Was Decedent Ever in	1118 13	Was Decedent of H	21502	inecity Yes or No-	USA 14. Bace -	American Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if itsm 27 is marked other than "natural", or items 23a or 28s-1 show says injury or other traumatic avant, the Medical Examinant must be indiffied at ance.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No		Was Decedent of HIf Yes, specify Cub	Specify:	to Rican, etc.)	Black, Specify:	White, etc.
2-0	72 ho	eted	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occup	during most of wo	rking	16b. Kind of Busin	ness/Industry
121	within ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4+	teache	DO NOT use retire	d)		education	1
<u>1</u> 02	illed Hygid other	e Co	17. Father's Name (First, Middle, Las	')	TOGOTIC	<u> </u>		me (First, Middle,	Maiden Sumame)	
ylar	ouid be Menta arked artic so	To Be	Emory Melvin N	/IcKenzie			Elizabe	eth M. Mo	Bee McK	enzie
, Mar	and 2 sho salth and n 27 is m		19a. Informant's Name/Relationship James McKenzie	brother	137	32 Spruce	Spring F	Rd Cresa		MD 21505
Baltimore, Maryland 21215-0036	Pages 1 nent of He ant: if itsr ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery, cre	osition (Name of matory or other pla ineral Home	^{се)} e, Р.А.	2/17/2006	Cresapto	
Balt	permit. Departr imports sny inj		21. Signature of Funeral Service Lice	esee MMM	2	2. Name and Address Scarpel 108 Vire			land, MD 2	1502
Е			23a. Par11 Enter the disease, or construct, or heert failure. List only	nplications that caused the d one cause on each line.	eath. Do not en	C 1		Δ.		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a trecos	denti	2 Gardin) vascula	- Pisc	are	
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Ļ	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):					
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8760,	cate be executed bhysician and the burial-transit	calE		d						
9	e as th	Medi	IF FEMALE:							
.O. Box	The law requires that the death certificate be executed to hes been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date Month	
<u>α</u>	w requires that is been signed by should be deta	ρ	Part II. Other significant conditions	contributing to death but not	resulting in the L	underlying cause gr	ven in Part I.	23e. Did to	_	ute to the cause of death?
COL	law req es beer 2 shou	olete						24a. Was	an 24b. We	re autopsy findings available
ai Re	n: The lav licete hes rr. page 2	Completed					A 144	Yes	rmed? 2 ☐ No	or to completion of cause of 2 ? Yes 2 □ No
\equiv	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1,∑ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2	P ☐ ER/Outpatie	nt 3 DOA Ott	200	ath <i>Ch</i> ec <i>k onl</i> √ o Home 5 ☐ Resid	<i>ne</i> l dence 6.Mother	(Specify) At scene
Division of Vital Records,	Attending Ph or death. ector: After thi by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Wo	ryat rk?]Yes 2 □No	28d. Describe	now injury occurred	
Divis	al or Attand s after death il Director: ,	Certification:	3 Suicide 6 Could not l 4 Homicide determined			reet, factory, office		28f. Location (5 City or Tox	Street and Number vn, State)	or Rural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete h completely filled in by the funeral director, page	Medical C		hysician: To the best of my miner: On the basis of exam and manner stated.						
	Within To th	Ž	29b. Signature and title of certifier	0		29c. Licen			29d. Date signed (Month, Day, Year) 17, 2006
			Cont	men)			enn Stree	at Ralta		ryland 21201
_	6		30. Name and address of person who	LE (M)		, Print) III I	CITT DELEC			
-8.	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 4 2006	32. Registrar's Si		م				

			For State Registrar	State	of Ma	ryland		rtment of H tificate of I		and M		jiene	006	05603
	Dhusisi		1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		Virginia	M			Not	cton			Februar	y 2	2006	8:05 P ^M
	Examin	er	4a. Facility Name (If not institution	_				4b. City, Town, or		of Death			nty of Death	
_			Anne Arunde1 5. Social Security Number	Medical (st birthday)	Annapo		24 Hrs.	8. Date of Birtl		ne Aru	
	Funeral Director		048-18-7608	1 □ M 2 X X	-	(<i>III yr</i> s. <i>Ia</i> s	Yrs.	Months Days	Hours		July 23	Year)	Cour	place (State or Foreign htry) ecticut
			Usual Residence of Decedent								oury 23	,1723	GOIII	ecticat
	nylan how		10a. State 10b. County			-	Town or Lo						1	Od. Inside City Limits
	Ba-f	cto		Arundel		Cr	ownsv	ille						1 ☐ Yes 2√XVo
	vith th	Dire	10e. Street and Number					10f. Zip Code					of What Cour	ntry?
	death with the Maryland me 23a or 28a-f ehow Effival be froilling at	eral	2018 Haverfor	12. Was De	andont F	une in 11 C	12.1		.032	-i-2 /C	ait. Van as Na		SA Race - Americ	na ladias
136	be filed within 72 hours after death with the Marylan ital Hygiane. Id other than "natural", or Iteme 23a or 28a-f ehow event, Its Medical Exerting must be rotified at	by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 🛣 Divorced	ned 1 Yes	Forces? 2 X∑X No Sive		It	Vas Decedent of H Yes, specify Cuba	Specify:	gin: (Spe i, Puerto F	Rican, etc.)	E	Black, White,	
215-0036	2 hou	Completed		nt's Education			16a. Deced	lent's Usual Occup	ation			16b. Kind o	f Business/In	dustry
Z	within 72 ane. than "nai	ed l	(Specify only higher Elementary/Secondary (0-12)	T .	(1-4or 5+	+)	life. L	kind of work done OO NOT use retired	auring mos d)	t of workin	ig			
7	filed wil Hygian other th	Col	12				Execut	ive Secr					suranc	e
Maryland	should be file nd Mental Hyg marked othe umatic event,	Be	17. Father's Name (First, Middle,								(First, Middle,	Maiden Sun	name)	
<u>Ş</u>	should bind Ment	ဠ	Walter Murdick							Spe				
<u>a</u>	12 sh h and 7 is n traun		19a. Informant's Name/Relations Michele E. Wil		ah+	tor)		g Address (Street Haverfor				-		
	es 1 and 2 should b of Heelth and Ment f Item 27 is marked r other traumatic e		20a. Method of Disposition	TIAMS (Da	ugnt			sition (Name of natory or other place			ate		on - City or To	
Baltimore,	permit. Pages Depertment of I Important: If It any injury or o		1 ☐ Burial 2 【XCremation 4 ☐ Donation 5 ☐ Other (5		n State	1				2-7-2	006		•	
┋	nit. P ertme ortan injur		21. Signature of Funeral Service] Met.		ematory . Name and Addre			000	Dailli	nore,	MD
ñ	Per	; 1	13- 2. C	gu-				Hardesty 12 Ridge	Fune	ral	Home, F	A.	MD 21	401
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that	caused t	the death.	Do not ent							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			000	1,00	for sh	oura					Onset and Death
	/Medical		resulting in death)	Due t	o (or as a	conseque	ence of):	1 1	7					
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09/80	cate be executed physicien and tha burial-transit	dical E		l a										
89		(D)		d.										
ROX	death certifi e attending id for use as	M/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome o	of pregnance	cy	Ectopic pregnancy				23d.	Date of delive	эгу
	0 0 0	by Physician/M	in the past 12 menths? 1 ☐ Yes 2 ☑ No		gnant at t	time of dea		Other (specify)	, 				Month	Day Year
J.	at the	Phy	9 Unknown											
ś	law requires that the dei as been signed by the a 2 should be detached f		Part II. Other significant conditi	ons contributing to	death bu	it not result	ting in the u	nderlying cause giv	ren in Part I			obacco use d		he cause of death? Dably 4; Unknown
Records ,	w require been si should b	eted	7.00	Lance L	- 1	11								
ခို	sician: The law certificate has b irector. page 2 s	Completed	gaul	we to		MIC	10_				24a. Was autop perio	sv	4b. Were auto prior to co death?	opsy findings available impletion of cause of
	n: Th		25. Was case referred to medical								1 ☐ Yes	2 No	1 🗆 Yes	2□ No
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<u></u>	ding Phys h. After this funeral di		27. Manner of Death	28a. Dai	e of Injun	y 2	28b. Time of		y at		28d. Describe			y /
<u></u>	ath. r: Aft	atio	1 Natural 5 Pendi 2 Accident invest	ng (AM) igation	onth, Day	1941)	Injury		Yes 2□	No				
Division of	Hospital or Attending 24 hours efter death. Funeral Director: After tely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 288. Pla	ce of Inju Iding, etc	iry - At hon :. (Specify)	ne, farm, str	eet, factory, office		2	28f. Location (5 City or Tox		mber or Run	al Route Number,
	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	Medicai C	29a. Certifier (Check only one) Certifyi Certifyi Certifyi	ng Physician: To t Examiner: On the and ma	he best o basis of anner stat	examination	rledge, deatl on and/or in	n occurred at the till vestigation, in my o	me, date ar opinion, dea	nd place, a	and due to the	cause(s) and date and pla	manner as s ce, and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certific	ər				29c. Licens	e number			29d. Date si	gned (Month,	Day, Year)
			1					DE	1702	28		2	-6-0	06
			30. Name and addess of person	who completed ca	use of de	eath (Item :	23а) (Туре,	1			nau			
-			31. Date filed (Month, Day, Year	1am.D	· lot	00 K	lace	ly Ave	#23	1 /1	nnap	01151	MD.	21401
	Sta Registi			8 2006	100	ar's Signatu	B A	book						

		1	For AMEND#29b 2/8/06 State Pegistrar PER AA. COUNTY	State of Maryland /	Department of H Certificate of I			ene 2006	05604
П	Physicia		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Yeer	3. Time of Death 1:00 AM M
В	/Medic	al	Amanda A. Nunley	and and another	4h City Tourn or	Location of Death	February	6, 2006 4c. County of Death	
Н	Examin	er	4a. Facility Name (If not institution, give s Genesis Eldercare		·	Annapolis		Anne Arun	
	Funeral Director		5. Social Security Number 6. Sex		irthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y Mar 23,	9. Birth Cou 1916 Tenne	place (State or Foreign ntry) ESSEE
	P	h	Usual Residence of Decedent 10a, State 10b, County	100 City To	wn or Location				10d. Inside City Limits
	anylau show		_		Annapolis				1 Tes 2 No
	the M 28a-f	ect	MD Anne Aru 10e. Street and Number	ildei	10f. Zip Code		100	g. Citizen of What Cou	
	with Baor	Funeral Director	3542 Narragansett	Avenue	21403		Uı	nited Stat	es
	ns 23	era		12. Was Decedent Ever in U.S.	13. Was Decedent of H	ispanic Origin? (Spec	city Yes or No-	14. Race - Ameri	
5-0036	2 should be filed within 72 hours after death with the Maryland and Manthe Hygiens. Is marked other than "natural", or items 23a or 28a-f show armarked other than "natural", or items 20a or 28a-f show aumatic event, the Medical Exum or must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Ovorced	Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2DXNo	an, Mexican, Puerto F Specify:	ican, etc.)	Black, White Specify: Black	, etc.
2	72 ho natur	ted	15. Decedent's Edu (Specify only highest grade		a. Decedent's Usual Occup (Give kind of work done)	during most of working	~	Sb. Kind of Business/In	
2	nithin nan " nan "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO NOT use retired ducator	d)	5	cate Gover	immeric
Maryland 2121	iled w dygiei ther ti	S	17. Father's Name (First, Middle, Last)	4 15	ducator	18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
and	a = >	o Be	Edgar V. Nunley			Cora Gut	hardt		
<u> </u>	should and Man s marke umatic	우	19a. Informant's Name/Relationship (Ty	pe, Print) 19	b. Mailing Address (Street	and Number or Rura	Route Number,	City or Town, State, Zi	ip Code)
	and 2 palth a n 27 is er trau		Edgar T. Nunley	4	707 Brinkley	Road Temp	_		
Baltimore,	of He		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State cemet	of Disposition (Name of ery, crematory or other plac gate Memoria	(e) F	eb 14	oc.Location-City or T nnapolis,	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature Finer Pervice Lic, rs	mat	22. Name and Addre Miller's 1922 Fore	ss of Facility Metropoli est Drive	tan Chap Annapol	el is, MD	
г	8 8 1		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. Do					Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a consequal co	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
В	Examiner		Sequentially list conditions,	. failue	LG	re			
	9d sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	9 UT).				
	cate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	e of):				
8760,	siciar b burit	Sal		d					
9	g phy as the	ledic							
.O. Box	The law requires that the death certific te has baen signed by the attending p tage 2 should be detached for use as:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 monthe? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 Ectopic pregnancy 5 Other (specify)	у		23d. Date of dela Month	very Day Year
<u>α</u>	w requires that been signed by should be deta	by	Part II. Other significent conditions co	ntributing to death but not resulting	in the underlying cause give	ven in Part I.		acco use contribute to	
Vital Records,	The law require tate has been single page 2 should	Completed					24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of 2 No
ita	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?			26. Place of Death	Check on one		
∑ _<	N S	으	1 ☐ Yes 2 ☐ No	The second secon	Jutpatient 3 DOA			nce 6 Other (Spec	cify)
n	ding Ph h. After th funeral	on:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b	Time of M 28c. Injury Wo M 1		28d. Describe how	w injury occurred	
Division of	Hospital or Attending F 24 hours after death. Funeral Director: After tely filled in by the funer	ertification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)			28f. Location (Str. City or Town,	eet and Number or Ru , State)	ral Route Number,
L	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director:	edical Ce	29a. Certifier Certifying Phy	rsician: To the best of my knowled iner: On the basis of examination and manner stated.	ige, death occurred at the ti and/or investigation, in my	me, date and place, a opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the l within 2. To the i	Med	29b. Signatore and title of certifier		29c. Licen:	se number	29	d. Date signed (Monti	h, Day, Year)
	⊢ s ⊢ ŏ		X AX	3000	г	57028		2-8-06	
			30. Jame of a viress of person who c	ompleted cause of death (Item 23a		e. #231,	Annack	2-8-06	.21401
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 8	32. Registrar's Signature	4 South	/			

			For State Registrar	State of	Marylan		artment of H		d Mental Hyg	iene	05605
			Decedent's Name (First, Middle, Lateral	st)					2. Date of Deal	h	3. Time of Death
	Physicia		Teresa	Marie		Newto	n		Februar	y 2 20	006 8:00 p M
	/Medic Examin		4a. Fecility Name (If not institution, give	e street and num	iber)		4b. City, Town, or	Location of D	eath	4c. County of	Death
			220 Lookout Lane				Annap	olis		Anne	Arundel
	Funeral		5. Social Security Number 6. S		7. Age (In yrs.	last birthday)	If Under 1 Year Months Days			Year)	9. Birthplace (State or Foreign
	Director		124-34-3383	□M 2(X F	61	Yrs.	Wionans Days	110013	Sept.	6,1944	New York
	pu >		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	astion				10d. Inside City Limits
	aryla shov	_		1 . 1							1 ☐ Yes 2 🔀 No
	Ba-f	Director	MD Anne Ar	unaeı	An	napoli				0- 0%	
	with t		10e. Street and Number				10f. Zip Code	400	'	0g. Citizen of Wh	nat Country r
	eath na 23	erai	220 Lookout Lane	12. Was Dece	dent Ever in II	S 13 1	1	409	7 (Specify Yes or No-	USA 14. Bace	- American Indian,
_	Herr d	Funerai	11. Marital Status 1 □ Never Married	Armed For	ces?	10.	f Yes, specify Cuba	in, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)		White, etc.
2	urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	8		1□Yes 2XX No	Specify:		Specify:	White
9500-61212	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation		16a. Dece	dent's Usual Occup kind of work done of	ation	working	16b. Kind of Busi	iness/Industry
7	thin 7	ple	Elementary/Secondary (0-12)	College (1-	-4or 5+)	life.	DO NOT use retired	ding most of			
7	er th	Con		4		Teach	er				y Education
Maryland	al Hy al Hy bvent	Be	17. Father's Name (First, Middle, Last,					18. Mother's	Name (First, Middle, I	Maiden Sumame))
<u>X</u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or itema 23a or 28a-1 show aumatic event, I're Medical Exameter must be notified at	ဥ	Joseph Bauer						trude Meye		
<u>a</u>	and is m		19a. Informant's Name/Relationship (r Rural Route Number		tate, Zip Code)
	es 1 and 2 should to of Health and Ment fitem 27 is marked rother traumatic		David L. Newton	(Husban				ane, An	napolis, N		T
9	Pages 1 nent of H int: If Iter iry or oth		20a. Method of Disposition XXBurial 2 Cremation 3	Removal from S	1 /	emetery, crer	sition (Name of natory or other plac	e)	Date	20c, Location - C	ity or Town, State
	Pag tmen tant: jury		* 4 □ Donation 5 □ Other (Specif		Arl		Nat. Cer				n, Virginia
Baltimore,	permit. Pages Department of I Important: If It any Injury or o		21. Signature of Funeral Service Lice	* Ju-	-	22			al Home, P nue, Annap		21401
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca	aused the deat	h. Do not ent					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	0110 04400 011 00	Moto	stati	c Color	_	incer		Onset and Death
	/Medical		resulting in death)	a Due to (or as a conseq	uence of):	<u> </u>	• • •	(VCCC ·		190
	Examiner		Sequentially list conditions	b							
	od sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
	The law requires that the death certificate be executed tie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):					
8/60,	be exicient			000 10 (1	or 23 2 3011304	451140 01).					
ğ	icate phys s the	edicai		_ d.							
ö	eath certific attending p I for use as 1	/We	IF FEMALE:	23c. If yes, outo	come of pregna	incy				23d. Date	of delivery
n	atter I for u	Physician/M	23b. Was decedent pregnant in the past 12 months 1 ☐ Yes 2 ☐ MO	1 ☐ Live bi	irth 2 Feta ant at time of d	Ideath 3[Ectopic pregnancy Other (specify)			Monti	
oj.	nrequires that the de been signed by the should be detached	ysi	9 Unknown	9□ Unkno	wn						
ح	s that ned b a deta	by PI	Part II. Other significant conditions	ontributing to de	ath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	pacco use contrib	oute to the cause of death?
200	quires n sign	d b							1 🗆 Yı	es 2 1 No 3	B ☐ Probably 4 ☐ Unknown
ecords,	w rec	Completed							24a. Was a	n 24b. We	ere autopsy findings available
E E	alclan: The law certificate has b irector, page 2 s	E C							autops perform	ned? de	ior to completion of cause of ath?
Vital		d)	25. Was case referred to medical					26 Place of	1 ☐ Yes :		Yes 2 No
	yalclan: is certifica director,	O	examiner?	Hospital:	npatient 2	ER/Outpatier	nt 3 DOA Oth	ec.	ng Home 5 Preside		(Specify)
0	g Phy er thi	n: T	27. Manner of Death		of Injury h, Day Year)	28b. Time o		y at		ow injury occurred	
DIVISION	Attending P death. ctor: After I y the funera	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio		ii, Day Teal)	Injury		Yes 2 □ No			
VIS	Atte	iffic	3 ☐ Suicide 6 ☐ Could not be determined	208. Flace	of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (Si City or Town		or Rural Route Number,
5	s after or salter or salte	Certification:	4 1 10111000	Julian	ig, 6to. (<i>Opbon</i>	<i>y</i> /			0.0, 0.7 10.11	, olulo)	
	To the Hospital or Attending Phyalclan: Within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director.	edical (isis of examina				lace, and due to the coccurred at the time, d		
	Nithin Fo the	Me	29b. Signature and title of certifier	01			29c. Licens	e number	2	9d. Date signed ((Month, Day, Year)
	> - 0) qualla	W.	ND		DO	Aslal	7	-etravi	13,2006
			30. Name and address of person who			n 23a) (Type,		WWO.		- 1: Out 0	1 , 00 - 00
			0 1 1.1	o North		Street		ore Ma	aryland:	21287	
	Sta	te	31. Date filed (Month, Day, Year)		gistrar's Signa		_		7		
	Registr	ar	FEB 0 8 2	006	The same	K 1	marke				
_				.,			-				

		,	• • • • • • • • • • • • • • • • • • • •	te of Maryland / D		ealth and M	lental Hyg	iene eg. No.		05606
	Physici		1. Decedent's Name (First, Middle, Last) Dorothy M.	Nicholas			2. Date of Deat		200 ° 6°	3. Time of Death 4:27 рм
	/Medic Examin		4a. Facility Name (If not institution, give street a Fort Washington Hosp		4b. City, Town, or Ft. Wash				County of Death	orges
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2:	7. Age (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 7, 1	930	9. Births Cour Mary	place (State or Foreign ntry) Land
Maryland	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Prince Geo	10c. City, Town	or Location shington				1	10d. Inside City Limits 1√1 Yes 2 □ No
th this	a or 28 Le no	i Dire	10e. Street and Number 2201 Calhoun Street		10f. Zip Code 2074	4	1	0g. Citiz	en of What Coul	ntry?
occurs after death	Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23s or 28s-f show eny injury or other traumatic event. If a Medical Examination and proce.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Fr	s Decedent Ever in U.S. ned Forces?]Yes 26 No es, Give ar or Dates:	13. Was Decedent of Hi If Yes, specify Cubar 1 Yes 2 No		ecify Yes or No- Rican, etc.)	i	4. Race · Americ Black, White, Specify: Bla	etc.
12.13.13 10.10.13.13	iene. r than *nature ire Medical E	Completed	15. Decedent's Education (Specify only highest grade comp. Elementary/Secondary (0-12) Co 12 years	oleted) 16a. [(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired OSMETOLISIS	tion uring most of work t	ing		d of Business/In	•
Mana &	Aental Hygirked other	To Be C	17. Father's Name (First, Middle, Last) Joseph Lane			18. Mother's Name	ian Lewi		Битате)	
Vial y	th and h		19a. Informant's Name/Relationship (Type, Pri Rev. John J. Nicholas/		Mailing Address (Street a					c Code)
ווסיבי, מינים ביי	ent of Heal nt: If Item 2 ry or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Remove 1 ☐ Donation 5 ☐ Other (Specify)		Disposition (Name of control of c	2/14,) 2006 R		ation - City or To	
	Departm mportal ny inju		21. Signature of Funeral Service Ocensee		JOHN T. RH					
	hysician /Medical xaminer			Myocardial Due to (of as a consequence of	Infarction	g, such as cardiac	or respiratory arr	est,	1010,10.0	Approximate Interval Between Onset and Death
The law conjugation that the death conflicted to executed	beath. tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the buriat-transit	edical Examiner	Cause (Disease or injury that initiated events	Due to (or as a consequence of						
The death codil	y the attending	Physician/Med	in the past 12 months?	es, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown	3 Ectopic pregnancy 5 Other (specify)	MA		2	3d. Date of deliv Month	ery Day Year
COLDS, T	an signed build be deta	þ	Part II. Other significant conditions contributi	ng to death but not resulting in	the underlying cause give	en in Part I.		bacco us es 2		the cause of death?
	ate has bee	Completed					24a. Was a autops perform	sy	24b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of No
VICAL	certific lirector.	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospita	l: 1 ☐ Inpatient 2 X ER/Out	patient 3 DOA Othe	26. Place of Deat	h <i>(Check only or</i> ome 5 ☐ Resid		□Other (Speci	fv)
DIVISION OF VICE	nth. r: After this e funeral d			. Date of Injury 28b. Ti	ime of 28c. Injury	at	28d. Describe h			77
DIVISION	within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28c	. Place of Injury - At home, fam building, etc. (Specify)	m, street, factory, office		28f. Location (S City or Town		l Number or Run	al Route Number,
1001	vithin 24 hours after on the Funeral Directory ompletely filled in	edicai	(Check only 2 Medical Examiner: O	To the best of my knowledge, in the basis of examination and id manner stated.	Vor investigation, in my of	oinion, death occur	red at the time, o	late and	place, and due t	to the cause(s)
,	within sompl	Me	29b. Signature and title of certifier		29c. Licanse	number ///82_	2	9d. Date	signed (Month,	Day, Year)
		2	30. Name and address of person who complete	ed cause of death (Item 23a) (1	Type, Print) Type, Print) Type Crimysfun There	Rd #	350 F	ort 1	intsitive	500, MO
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registrar's Signature	book					

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State of Maryland / Department of Health and Months Certificate of Death		giene Reg. No	UUb	05607
			1. Decedent's Name (First, Middle, Last)	2. Date of De. Month			3. Time of Death
	Physicia /Medic		IIO I IO MOTE NOTE I AND	Februa	ry 1		1528 P M
į.	Examin	er			4c.	County of Deat	h
			1817 Appleton Road E1kton 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.	9. Date of Bird		Cecil	
L	Funeral Director		220-32-3050 1 M 2 K 91 Yrs. Months Days Hours Min.	8. Date of Bird (Month, Da May 15	, Year)	14 Ma	hplace (State or Foreign untry) ryland
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Manyl f sho	jo	Maryland Cecil Elkton				1 ☐ Yes 2 📉 No
	r 28e	Director	10e. Street and Number 10f. Zip Code		10g. Cit	izen of What Co	untry?
	death with the Maryland rms 23e or 28e-f show rrrust be notified at	ai D	1817 Appleton Road 21921		U	nited St	tates
	deat	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spendent of Yes, specify Cuban, Mexican, Puerto F	cify Yes or No	_	14. Race - Ame Black, White	rican Indian,
2-0036	72 hours after death with the Marylan "naturef", or items 23e or 28e-f show idical Examiner must be notified at	ρ	If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates;			Specify:	hite
בְּ	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	200	16b. K	ind of Business/	
N	within and the series of the s	npie	Elementary/Secondary (0-12) College (1-4or 5+)	ig .			
V	ed wi ygien yer th	Cou	8 Seamstress				ufacturing
ana	be fill	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name			Sumame)	
2	J Mer narke	ဥ			_	- T	T'- O- 4-1
<u> </u>	d 2 st th and 7 ier treur		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Vincipie N. Buckingham/Doughton 219 Most Main Street N				
a)	1 and Healt em 2	LU,		ate		cation - City or	
банттог	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 ie marked other than any injury or other treumatic event, the Magnes.		1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 1 Donation 5 Other (Specify) 1 Donation 5 Other (Specify) 1 Cemetery			ark, Del	
n D	Depart Import any in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Fune 103 W. Stockton Str	rals, I	P.A.	n Marv	land 21921
	1		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.			,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition acidi my record and his				Onset and Death
	/Medical		resulting in death) a Due to (or as a consequence 1):				
	Examiner		Sequentially list conditions b. Corning 2rding Disea	-5e			
1	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
V	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	-5e			
Ĉ,	be exician ician buria						
09/90		edicai	d				
XOD						23d. Date of dei	ivery
Ď	0 0	hysician/M	in the past 12 months? 1			Month	Day Year
5	t the by the tache	hys	9 □ Unknown				
'n	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t			the cause of death?
	equira en si ould i			10	Yes 2	ÄNo 3□Pr	obably 4 Unknown
ecords,	law re as be 2 sh	ompieted		24a. Was	osv	l prior to a	topsy findings available completion of cause of
r	The law ate has b page 2 st	Соп		perfo	mad? 2 A No	death?	2 🗆 No
VICA	cien: ertific actor,	Be (25. Was case referred to medical axaminer?	(Check only o	one)		
5	hysi this c	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon				cify)
	After unera	lon:	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28 Natural 5 Pending (Month, Day Year) 28b. Time of 28c. Injury at 28c. Injury 28c	8d. Describe	how inju	ry occurred	
<u> </u>	ttend death tor: / the f	icat	2 Accident investigation 3 Suicide 6 Could not be 380 Place of Injury 4t home farm street feature of inc.	19f Loostion /	Stroot at	ad Alumbar or Pi	ıral Route Number,
DIVISION OF	el or A s after of Direct	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or To	wn, State	e)	irai noute Nomber,
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edical (29a. Certifier (Check only (Check only and other continuous) 29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a continuous of examination and/or investigation, in my opinion, death occurred to the date of examination and/or investigation, in my opinion, death occurred to the date of examination and/or investigation, in my opinion, death occurred to the date of examination and/or investigation, in my opinion, death occurred to the date of examination and/or investigation, in my opinion, death occurred to the date of examination and/or investigation, in my opinion, death occurred to the date of examination and/or investigation, in my opinion, death occurred to the date of examination and/or investigation, in my opinion, death occurred to the date of examination and/or investigation, in my opinion, death occurred to the date of examination and/or investigation, in my opinion, death occurred to the date of examination and/or investigation, in my opinion, death occurred to the date of examination and/or investigation, in my opinion, death occurred to the date of examination and/or investigation, in my opinion, death occurred to the date of examination and/or investigation, in my opinion, death occurred to the date of examination and/or investigation, and the date of examination and occurred to the date occurred t	d at the time,	cause(s date and) and manner as d place, and due	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier 29c. License number		29d. Da	te signed (Monti	h, Day, Year)
			D000 4823		2	116/06	
	10		29b. Signature and title of certifier 29c. License number	St. 6	EH	ton M	L. 21921
	Sta Registr	-	31. Date filed (Month, Day, Year) FEB 2 4 2006 32 Registrar's Signature				

_			1 - For State Registrar			artment of He ertificate of D			Reg. No.	05608
	Physici /Medi		Decedent's Name (First, Middle, La Ann Frances Ott	,				2. Date of De Month Februar		3. Time of Death 4:30 PM
	Examir Funeral Director			al	e (In yrs. last birthday 70 Yrs.	4b. City, Town, or L Silver Sp If Under 1 Year Months Days		8. Date of Bin (Month, Da Nov 30	4c. County of De Montgome	
	nyland show		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	s 1 end 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other then "naturel", or Itema 23e or 28e-f show other treumatic event, Ita Medical Examinar must be notified at	al Director	Maryland Montgom 10e. Street and Number 2702 Randolph Roa		Silver Sp	oring 10f. Zip Code 20902			10g. Citizen of What (1 Yes 2 No
900	72 hours after dea naturel', or Itema dical Examiner m	I by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 1 Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 XNo	panic Origin? (Sp. Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Specific	
Maryland 21215-0036	e filed within 72 ha al Hygiene. I other then "natu vent, the Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation a de completed) College (1-4or 5	i+) (Giv	edent's Usual Occupation in the kind of work done dured to NOT use retired in Guard	on <i>ring</i> most of work	ng	16b. Kind of Busines Public Saf	
yland	12 should be file and Mental Hyg Is marked othe reumatic event,	To Be C	17. Father's Name (First, Middle, Last			nknown) M	lary Mago	lo1yn	Maiden Surname)	
e, Mar	is 1 and 2 sh of Health and item 27 is rr other traum		19a. Informant's Name/Relationship Michael Otts/son 20a. Method of Disposition	Type, Print)		Watercraf	t Court	Olney,	MD 20832 20c. Location - City of	
Baltimore,	it. Pege rtment o rtant: if njury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Signature) of Funeral Service Lice	(y)	Chesapea	ematory or other place) ke Cremato	ry 10,	ruary 2006	Beltsville	e, Maryland
Ba	Depermination of the series of		23a. Part 1. Enter the disease, or con	Houte	the death. Do not er	everly L.	Heckrott	e, P.A.		Approximate
	ificate be executed 3 physicien end as the burial-transit	Il Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Severe C Due to (or as b. Chronic Due to (or as c. Osteoror Due to (or as	hronic Obs a consequence of): Anemia a consequence of): osis a consequence of):	tructive P	ulmonary	Diseas	6e	Interval Between Onset and Death
.O. Box 68760,	death certif e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome	2 Fetal death 3	Prieumonia □Ectopic pregnancy □ Other (specify)			23d. Date of d Month	elivery Day Year
Q.	w requires that the been signed by th should be detache		Part II. Other significant conditions of Gastro esophageal			underlying cause given	in Part I.		obacco use contribute Yes 2 □ No 3 🖔 t	to the cause of death? Probably 4 Unknown
of Vital Records,	The law ate hes b page 2 si	Completed by	Degenerative join	t disease	CONTRACT CON				osy prior to rmed? death?	autopsy findings available completion of cause of es 2 \(\text{No} \)
on of Vit	ding P	ion; To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da)	nt 2 ER/Outpatie	of 28c. Injury a Work?	4 Nursing no	me 5∐Resid	one) dence 6 Other (Sp now injury occurred	ecify)
Division	To the Mospital or Attanding Ph within 24 hours eiter death. To the Funeral Director: Atter th completely filled in by the funeral	Certification;	2 Accident investigatio 3 Suicide 6 Could not be determined	e One Place of Init	ury - At home, farm, si c. (Specify)			28f. Location (S City or Tox	Street and Number or I vn, State)	Rural Route Number,
	To the Hospital within 24 hours e To the Funeral I completely filled	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination and/or inted.	vestigation, in my opin	nion, death occurr	ed at the time,	cause(s) and manner a date and place, and do	ue to the cause(s)
		-	29b. Signature and title of certifier	Sauce		29c. License n			29d. Date signed (Mor February 8,	
(<u>)</u>	A Sta Registr		30. Name and address of person who Hava1 Saad11a M.D. 31. Date filed (Month, Day, Year)	. 1500 For	est Glen R ars Signature		Spring,	MD 2091	10	

		-	State of Maryland / Dep	partment of Health and Mental Hygiene pertificate of Death Reg. No. 0 10 10 10 10 10 10 10 10 10 10 10 10 1
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Helen A. Opalka 4a. Facility Name (If not institution, give street and number) Washington County Hospital	2. Date of Death Month; Day Year 0/25 M 4b. City, Town, or Location of Death Hagerstown 2. Date of Death Day Year 0/25 M 4c. County of Death Washington
	Funeral Director		5. Social Security Number 046-16-9830 6. Sex 1 \square M 2 \square F 7. Age (In yrs. last birthda Usual Residence of Decedent	Months Days Hours Min. (Month, Day, Year) Country) $06/29/1922 PA$
	the Marylan r 28a-f ehow	Director	10a. State 10b. County 10c. City, Town or MD Washington Hagers 10e. Street and Number	1 1 1 1 November 2 □ No
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f ehow event, the Midlical Examinar matter natified at	by Funeral D	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 11. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married	21740 US 3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2▼No Specify: Specify: White
Maryland 21215-0036	filed within 72 hour Hygiene. kther then "natural ent, the bisolical Ea	Completed t	15 Decedent's Education 16a Dec	sedent's Usual Occupation ve kind of work done during most of working DO NOT use retired) Seamstress Garment
/land	i 2 should be filed and Mental Hygie I is marked other raumatic event, iii	To Be C	17. Father's Name (First, Middle, Last) Paul Hemak	18. Mother's Name (First, Middle, Maiden Sumame) Antionette (unk)
	nd 2 salth ar 27 is r trau		Joseph Opalka, Jr. / Son 4 1	Fieldcrest Dr., Littlestown, PA 17340
Baltimore,	permit. Pages 1 a Department of Hee Important: If item any injury or othe		4 Donation 5 Other (Specify) Sacred Hea	position (Name of rematory or other place) art of Jesus Cem. 02/15/2006 Mayfield, PA 22 Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740
760,	Physician /Medical Examiner period and period in the print of the prin	cal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
O. Box 68	The law requires that the death certificate be executed at the bean signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Medi		3 Ectopic pregnancy 5 Other (specify) Month Day Year
0	juires that t n signed by lid be deta	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the DA buffer Mel. 705 typer c	e underlying pause oven in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
of Vital Records,	: The law require cate has been si page 2 should I	Completed	thyporteusion"	24a. Was an autopsy performed performed 1
Viita	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	26. Place of Death (Check only one) tient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify)
	ding Phy h. After thi funeral	tlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	
Division	or Attendation of the deal Director	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C		eath occurred at the time, date and place, and due to the cause(s) and manner as stated. r investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	Tath withir Tath comp	W	· Alon	29c. License number D 27 94 9 29d. Date signed (Month, Day, Year) 10 13 2006
31.	St. Regist	ate rar	30. Name and address of person who completed cause of death (Item 23a) (Tyling 1 and	Specker

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State RegistrarAmend 7/8 per FH 2/13/0 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month **Physician** PARKER CONSTANCE 10:15A M 02 02 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yearl 940 9. Birthplece (State or Foreign **Funeral** Hours 1 ☐ M 25 F 68 577-54-6245 65 Yrs. Washington, DC. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Itams 23a or 28a-f show the Medical Examiner must be notified at Prince George's MD. Accokeek M☐Yes 2☐No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20607 USA Maple Cross St. 2413 deeth v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify.Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3X Widowed 4 ☐ Divorced 'naturel' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "nt any Injury or other traumatic event, tra Mudit once. Government Elementary/Secondary (0-12) College (1-4or 5+) Government Worker 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Penn Agnes Miles Theodore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 2413 Maple Cross St., Accokeek, MD. 20607 Angela P. Jefferson, 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State Laurel, MD. 20a. Method of Disposition 02/09/2006 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licepsee 22. Name and Address of Facility Bianchi F.S. 814 Upshur St. NW, Washington, DC. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VENTRICULAR FIBRILLATION **Physician** /Medical Due to (or as a consequence of): **Examiner** ACUTE ISCHEMIC CVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown certificete hes been s irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2X No within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 Z Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Dey, Year) 02/02/2006 29b. Signature and title of certifier 29c. License number MD 62571 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bromeland, MD. 1500 Forest Glen Rd., Silver Spring, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 8 2006 Registrar

			1 - For State Registrar		State of	Marylar				lealth and Death		Reg.	4000	0561	Вынушы шы
*	Physici		1. Decedent's Name	(First, Middle, Last) ck Oscar	Pierce						Mon	of Death th I	Pay Year 7 200	3. Time of Do	
	/Medic Examin		4a. Facility Name (If r					4b. City,	Town, o	r Location of Dea	ath		4c. County of Dea		
	AT THE RESERVE	#		Community	Hospi				Lanh				Prince G		
1	Funeral Director		5. Sociał Security Nur 212–20–27	UZ	M 2□F	7. Age (In yrs. 78	Yrs.	Months	1 Year Days	Hours Min	n. 12/	of Birth th, Day, Yes 31/27		rthplace (State or F ountry) ryland	Foreign
	land bw		Usual Residence of D 10a. State	Decedent 10b. County		10c. Ci	ty, Town or L	ocation						10d. Inside City	Limits
1	Mary -1 eh	ţō	Md.	P.G.					Lan	ham				1 Yes 2	□ No
2	ath with the Marylar 8.23a or 28e-f show ust be mulfied at	Funeral Director	10e. Street and Numb	ber				10f. Zip	Code			10g.	Citizen of What C	country?	
7	ath w	rai		coln Ave.						706			U.S		
(o)	after dea or items	nue	11. Marital Status 1 X Never Married		Armed For			Was Dece If Yes, spe	dent of F cify Cubi	lispanic Origin? an, Mexican, Pue	(Specify Yes erto Rican, e	or No- tc.)	14. Race - Am Black, Wh		
036	urs af	þ	3 Widowed 4		1 😡 Yes If Yes, Give Year or Da	1945 1947		1 🗆 Yes	2 X No	Specify:			Specify:	Black	
5-0	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or items 23a or 28a-f ehow ent, the Martical Examinational be multied at	Completed	(Specify	15. Decedent's Educ y only highest grade	ation completed)	1911	16a, Dece	edent's Usu e kind of wo	al Occur ink done	pation during most of w	orkin g	16b	. Kind of Busines	s/industry	
7 121	within ene. then	duc	Elementary/Second	dary (0-12)	College (1-	-4or 5+)		stodia		a)			College		
A 2	be filed within tal Hygiene. Ind other then event, the M	0	17. Father's Name (F	First, Middle, Last)				00001		18. Mother's N	ame (First, I	Middle, Maid			
`// /lar	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Manager aumatic event even	To B	George	W. Pierc	e					Eller	n Plat	er			-
$^{\prime}$ ederick $^{\prime}$ $^{\prime}$ $^{\prime}$ $^{\prime}$ $^{\prime}$	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marke any injury or other traumatic 2010e.		19a. Informant's Nam					•					ry or Town, State,		
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Frea Baltimore,	permit. I Departm Importal any injui		21. Signature of Fund		Pe -			2 Name a	nd Addre	ess of Facility					
ω	88188			my Kr	J10	U		4925_1	Burr	oughs Av	re.N.	E. Was	shington	D.C. 200)19
	Physician		23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition	failure. List only on inal	e cause on ea	aused the dear ach line. latory			de of dyir	ng, such as cardi	iac or respira	itory arrest,		Approximate Interval Betwe Onset and De Hours	en ath
	/Medical Examiner		resulting in death)	r a	Due to (or as a consec	quence of);							lour.s	
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	icate b physic s the b	edicai		d											
9 xo	eath certific attending p for use as	n/Me	IF FEMALE: 23b. Was decedent p	pregnant 23		come of pregn							23d. Date of d	elivery	
B	death of for	Physician/M	in the past 12 m 1 ☐ Yes 2 ☐	nonths?		irth 2 ☐ Feta ant at time of o		□Ectopic p □ Other (s)		у			Month	Day Ye	ar
P.O	that the de ed by the a detached		9 Unknown Part II. Dther signific	cant conditions con			sulting in the	underlying	rause on	ven in Part I	236	. Did tobaco	co use contribute	to the cause of dea	ath?
ds,	uires tha signed Id be de	d by		Anemia	and a mig to so		Jaking III (IIO	ongony ng ·	accoo gi				2 □No 3 □ I		
CO	aw require s been sig 2 should b	Completed	Depres	sion							248	. Was an autopsy	24b. Were	autopsy findings av	railable
Re	The law ate has page 2 s	Com	Septic	emia							1 🗆	performed Yes 2	? death	?	36 01
/ita	Physician: Th this certificate al director, pag	Be	25. Was case referre examiner?	ed to medical	ospital:				0"	26. Place of D					
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Division of Vital Records, P.O. Box	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral brector: After this certificate has been signed by the attending physicien and fiely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ertifica	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place buildir	ol Injury - At h ng, etc. (Speci	nome, tarm, s	treet, factor	y, office			ation (Stree or Town, S		Rural Route Numbe	97,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical Certification:		Certifying Phys		asis of examina									
	To the within 2 To the compler	Me	29b. Signature and ti	itle of certifier		•		29		se number			Date signed (Mo		
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CERVIEW WARFIELD PARLETT 40. Date of the control of point of the control of the control of the control of point of the control of t	· · · · · · · · · · · · · · · · · · ·	1 - State Registrar 1. Decedent's Name (First, Middle, Last)			ite of Death	and Mental H	Reg. No.	100	3. Time of Death
The Control of the Co	/Medical	GENEVIEVE V			v. Town, or Location of	Month	Try 3	2006	2225
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Sacrative and of working most of working Tell	3	Usual Residence of Decedent	10c. City.	Town or Location					10d Inside City Lin
MALTER G. WARFIELD 19a. Informant's Name/Balloanship (Type, Print) 19b. Mailing Address (Street and Number or Rual Abuse Mumber, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rual Abuse Mumber, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rual Abuse Mumber, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rual Abuse Mumber, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rual Abuse Mumber, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rual Abuse Mumber, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rual Abuse Mumber, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rual Abuse Mumber, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rual Abuse Mumber, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rual Abuse Mumber, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rual Abuse Mumber, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rual Abuse Mumber, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rual Abuse Mumber, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number of Rual Abuse Mumber, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number of Rual Abuse Mumber, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number of Rual Abuse Mumber, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number of Rual Abuse Mumber, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number, City Code) 19b. Mai	f sho				ON				1 □ Yes 2X
WALTER G. WARPTELD 19a. Informants Name Reliationship (Type, Print) 19b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute Number, City or Town, State, Zip Code) 17b. Mailing Address (Street and Number or Rusal Relute	r 28a	10e. Street and Number		10f. 2	Zip Code	<u> </u>	10g. Citizer	of What Cou	intry?
WALTER G. WARFIELD 9a. Informants NamePacialconsine (Type, Print) 9a. Informants NamePacialconsine (Type, Print) 9b. Maling Address (Street and Number or Russ Houle Variety or Town, State, Zip Code) 8746 DONCASTER RD. EASTON, MD. 21601 20b. Method of Disposition 1 Dunta 2 Command or Supplement of Disposition (Manual or Code) 1 Dunta 2 Command or Supplement of Disposition (Manual or Code) 2 Informants Name and Address of Facility. FELLOWS, IRLIFERBEIN & NEWNAM FUNERAL HOME P 2 OSS, HARRISON ST. EASTON, MD. 21601 2 Informants Name and Address of Facility. FELLOWS, IRLIFERBEIN & NEWNAM FUNERAL HOME P 2 OSS, HARRISON ST. EASTON, MD. 21601 2 Informants Name and Address of Facility. FELLOWS, IRLIFERBEIN & NEWNAM FUNERAL HOME P 2 OSS, HARRISON ST. EASTON, MD. 21601 2 Information Course (Final recipies) 3 Information Course (Final recipies) 4 Information Course (Final Recipies) 5 Information Course (Final Recipies)	23a o	8476 DONCASTER ROAL)		21601		U.S	.A.	
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EDWARD W. PARLETT / SON 8746 DONCASTER RD. EASTON, MD. 21601	To	WALTER G. WARFIELD			MAI	RIE HALE			
CHESAPEAKE CRM. CTR. 2-05-06 STEVENSVILLE, MD.	Is m		The same of the sa						ip Code)
22. Name and Address of Facility FELLOWS , HELFRENDEIN & NEWNAM FUNERAL HOME P.J. 203a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dyring-each as cardiac or respiratory afrees. 22a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dyring-each as cardiac or respiratory afrees. 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dyring-each as cardiac or respiratory afrees. 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dyring-each as cardiac or respiratory afrees. 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dyring-each as cardiac or respiratory afrees. 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dyring-each as cardiac or respiratory afrees. 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dyring-each as cardiac or respiratory afrees. 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dyring-each as cardiac or respiratory afrees. 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dyring-each as cardiac or respiratory afrees. 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dyring-each as cardiac or respiratory. 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dyring-each as cardiac or respiratory. 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dyring-each as cardiac or respiratory. 25b. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dyring-each as cardiac or respiratory. 25c. Part. Enter the disease, or complications that the mode of dyring-each as cardiac or respiratory. 25c. Part. Enter the disease, or complica	t: if item 27	20a. Method of Disposition 1 □ Burial 2 ★ Cremation 3 □ Remo	20b. Plac	ce of Disposition (A	lame of	Date	20c. Locat	ion - City or T	
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest. Approximate increase and caused (Final Indianal Redical Indianal In	nportani ny njury nce		1 1	22. Name	and Address of Facilit	у			
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23b. Was decedent pregnant in the past 12 months? 23b. Was decedent pregnant in the past 12 months? 23b. Was decedent pregnant in the past 12 months? 23b. Was decedent pregnant in the past 12 months? 23b. Was decedent pregnant in the past 12 months? 23b. Was decedent pregnant in the past 12 months? 23b. Was decedent pregnant in the past 12 months? 23b. Other (specify) 23d. Date of delivery Month Day Year 23b. It was an autopsy performed? 23b. Was an autopsy performed? 24a. Was an autopsy performed? 25b. Was case referred to medical examiner? 25b. Was case referred to medical examiner? 25b. Was case referred to medical examiner? 25b. Was case referred to medical 25b. Was case refer	an and rial-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequer Swall ly	wevel o	lion betruct	W			yang 8 days
Part	by the attending phy ached for use as the ached for use as the hysician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	l□Live birth 2 □Fetal de □Pregnant at time of dea □Unknown	eath 3 □Ectopid th 5 □ Other	specify)		23d		
25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Month, Day Year) 28b. Time of Injury Mork? 3 Suicide 4 Homicide 28a. Date of Injury At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number or Bural Ro	be d			ing in the underlying	cause given in Part I.				1
examiner? 1 Yes 25 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 2 Section 1 Section 1 Section 1 Section 2 Section 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred work? M 1 Yes 2 No Section 1 Section 2 Section 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred work? M 1 Yes 2 No Section 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred work? M 1 Yes 2 No Section 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred work? M 1 Yes 2 No Section 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred work? M 1 Yes 2 No Section 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred work? M 1 Yes 2 No Section 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred work? M 1 Yes 2 No Section 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred work? M 1 Yes 2 No Section 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred work? M 1 Yes 2 No Section 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred work? M 1 Yes 2 No Section 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred work? M 1 Yes 2 No Section 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred work? M 1 Yes 2 No Section 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred work? M 1 Yes 2 No Section 3 DOA Other: 4 Nu	has ye 2	25. Was case referred to medical			26 Place	au pe 1 \(\text{Yes}	topsy rformed? s 2 0 No	prior to co	ompletion of cause
27. Manner of Death Particle	9 8 m	Hospi	tal: 1 Vinpatient 2 Ef	R/Outpatient 3	Othor			Other (Speci	ıfy)
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)		Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year) Be. Place of Injury - At hom	Injury M	1 Yes 2	No 28f. Location	(Street and N		ral Route Number,
29c. License number 29d. Date signed (Month, Day, Year) DOUGOLO 2/4/06	Funer lely fill ical	29a. Certifier Certifying Physicial Crack only 2 Medical Examiner:	n: To the best of my knowle On the basis of examination	edge, death occurre	ed at the time, date an	d place, and due to the	ne cause(s) and	d manner as :	stated.
Sonox D0046020 2/4/06.	on the simple	one)	and manner stated.						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	28 -	> SMX				5020	200. Date S		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

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U	C	0	1	0

Physician /Medical
Examiner

altimore, Maryland 21215-0036 and Mental if of Health Pages

Bessie Pinder

ted by the attending physicien end detached for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 been signe should be s certificate has t lirector, page 2 s

Genesis HealthCare -Easton The Pines 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 M 2 KF Months Days Hours Director 214-32-1715 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or items 23a or 28e-f show other treumatic event, the Modical Examiner must be notified at Directo <u>Hurlock</u> Maryland Caroline 10e. Street and Number 10f, Zip Code deeth 4420 Preston Road 21643 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Switchboard Operator 17. Father's Name (First, Middle, Last) Be 2 William Adams.Sr. Virginia Nichols 19a. Informant's Name/Relationship (Type, Print) Tindley C. Pinder / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of H Importent: If Ite any Injury or ot 2002e. 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility
Bennie Smith Funeral Home 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 24a. Was an autopsy performe 2 No Iter death. Mector: After this certifica in by the funeral director, p or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ဥ 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury Certification: (Month, Day Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a, Certifier Medical 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb 2006 8:20 PM Bessie Marie Pinder 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Talbot Birthplace (State or Foreign Country) June 24,1936 Maryland 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian Black, White, etc. Specify: Black 16b. Kind of Business/Industry C & P Telephone Co. 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4420 Preston Road, Hurlock, Maryland 20c. Location - City or Town, State Federal Hill Ceemetery 02/15/06 Federalsburg, Maryland 516 S. Main Street, Hurlock, Maryland 21643 Approximate Interval Between Quset and Death 23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4X Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State

MICHAEL

5

610

Signature

MU

			1 - For State Registrar	State of Marylan				Mental Hy	giene	05611
	320				Cei	rtificate of L	Death		Reg. No. UUO	03014
	Physici	an	Decedent's Name (First, Middle, Last) Louis Pace					2. Date of Dea	Day Yea	
	/Medic		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Dea	Feb 4 2	4c. County of Di	1557
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Examin	er	Calvert Memorial F			Prince F		_	Calvert	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Birt	h 9.1	Birtholace (State or Foreign
	Director			M ^{2□ F} 75	Yrs.	Months Days	Hours Mir	Feb 25	1930 Ne	W Jersey
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	v. Town or Lo	cation				10d. Inside City Limits
	f sho	Ъ	Maryland Calvert		Lusby					1 ☐ Yes 2 ☐ No
	28a-	rect	10e. Street and Number		Барру	10f. Zip Code			10g. Citizen of What	
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show in Marilial Examinar must be mulliad at	by Funeral Director	50 Appeal Lane Ap	ot. # 220		2065	57		United St	ates
	ems 2	ner	11. Marital Status	Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? ((Specify Yes or No	- 14. Race - A Black, W	merican Indian,
99	or Its	y Fu	1 Never Married 2 Married	1 ZaYes 2 No		1 ☐ Yes 2 █ X No	Specify:	,,	Special	
Ö	urai',	q p	3 Widowed 4 Divorced	If Yes, Give Year or Dates 50-56	1 40- D	1 1 1 10				
21215-0036	in 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of w f)	orking	16b. Kind of Busine	ss/industry
72	iene.	omp	Elementary/Secondary (0-12)	Coflege (1-4or 5+)		nic auto	,		auto	
פ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
/lar	Menta Menta arked	ToE	Frank Pace				Carmel	a DeLaui	rentis	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or Items 23a or 28a-f show sny injury or other traumatic avent, the Madical Excriment must be notified at ance.		19a. fnformant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street a	and Number or F	Ru <i>ral Route N</i> um <i>be</i>	er, City or Town, State	e, Zip Code)
2	fealth		Frank Pace - son	20h 5	Man (D:	Manoe Ct		, MD 2065	57 20c. Location - City	or Town State
<u>S</u>	iges 1 or of F or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	emetery, crer	natory or other place tan Funer	feb 7 2	006	Alexandria	
Baltimore,	it. Pa intmer intent injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			2. Name and Addres	4 =			
Ba	Depa Depa Impo eny i		P 2						uneral Hom Republic M	
	9.2		23a. Part1. Enter the disease, or complic	cations that caused the deat						Approximate
	Physician		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.						Interval Between Onset and Death
熟。	/Medical		disease or condition resulting in death)	Due to (or as a conseq						
ä	Examiner		Sequentially list conditions b		asotid	Ende	anterec	ر آی		
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	·			Ĭ		
	and and I-trans	хагл	that initiated events resulting in death) Last	Due to (or as a conseq	∞ P D			V		
760,	ires that the death certificate be executed signed by the attending physician and doe detached for use as the burial-transit	cal E				siden-				
	ficate p phys		_ 0		7	pidu-				
XO	n certi anding use a	Physician/Med	fF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	ancy	Ectopic pregnancy			23d. Date of	delivery
P.O. Box	deat	sicia	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4 Pregnant at time of d		Other (specify)			Month	Day Year
<u>Ф</u>	at the	Phy	9 Unknown					00. 5.1.		
Ś	Attending Physiclen: The law requires that the death certifica refash. ctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it by the funeral director.	by	Part II. Other significant conditions con	induting to death but not res	ulting in the u	nderlying cause give	en in Part I.			e to the cause of death? Probably 4 Dlanknown
Ö	w requir been si should	Completed								
Rec	has law	mp				•		24a. Was autor perfo	osy prior death	autopsy findings available to completion of cause of
a	n: Th		25. Was case referred to medical				00 Di4 D	1 Tes		es 20No
5	/sicle s cert directe	To Be	examiner?	ospital: Inpatient 2	ER/Outpatier	ot 3 DOA Othe	or	eath (Check only o	dence 6 □Other (S	(necify)
סר	g Phy ter thi neral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				now injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
į	endin sath. or: Aff	atio	1 Natural 5 Pending 2 Accident investigation	(world, day roal)	,ary		Yes 2 □ No			
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (S City or Tox		Rural Route Number,
	To the Hospital or Attending Physiclen: The lav within 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2		29a. Certifier Certifying Phys	ician. To the best of and	worden de de	h accuration in	an data and -1	an and disc in the	anuna(a)	an attack
	Hos 24 ho Fun etely (Medicai	(Check only 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	ition and/or in	n occurred at the tim vestigation, in my or	ne, date and pla- pinion, death oc	ce, and due to the curred at the time,	date and place, and d	as stated. due to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signed (M	onth, Day, Year)
)	, , , , , ,		> D Shall M	D		D 5	0290		2-6-	06
	0 1 1		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type,	Print)) .			
0	(+1		Dhisen shew	mpleted cause of death (Iter 11.0 + 10 32. Registrat's Signa 2006	SP R	is t	BING	freder	ich MC	20678
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra 's Signa	ture H	Angel 1				
2.28	negisti	aı	ILD - /	LUUU P CEREUR	1 10.	Jan San San San San San San San San San S				

			For State Registrar	State o	f Marylar	-		nt of Health and te of Death	-	giene Rog. No.	006	05615
		-	1. Decedent's Name (First, Middle,	Last)					2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medic		Helen	Dunn	Perki	ins			Februar	y 12	, 2006	4:15 a.n.
	Examin		4a. Facility Name (If not institution,	give street and nur	nber)		4b. City	, Town, or Location of De	eath	4c.	County of Death	
1		2	St. Mary's	Nursing	Center			Leonardtown			St. Mary	/ s
	Funeral			6. Sex 1 □ M 2 □ XF	7. Age (In yrs.		If Unde Months	er 1 Year If Under 24 H	lin. (Month, Da	th ly, Year)	Cou	place (State or Foreign ntry)
7.	Director		215-36-4870	10 W 5076	84	Yrs.			March 2	3, 1	921 Virg	ginia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Loc	cation					10d. Inside City Limits
	feho	ō	Managara Ca	M I -								1 X Yes 2 ☐ No
	28a-	Director	Maryland St. 10e. Street and Number	Mary's			_	Leonardtown		10g. Citi;	zen of What Cou	ntry?
	with 3a or		22680 Cedar	Lano Cour	t Ant	#3106		20650		IIn f	ted Sta	tos
	hours after death with the Maryland turel', or Iteme 23a or 28a-f ehow at Exercitivational by nutified at	Funeral	11. Marital Status	12. Was Dece	dent Ever in U		Vas Deci	edent of Hispanic Origin? ecrfy Cuban, Mexican, Pu	(Specify Yes or No		14. Race - Ameri	can Indian,
ယ	after of the state	Fur	1 Never Married 2 Marrie		2 X No				ierto Rican, etc.)		Black, White,	
Ö	rel', c	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	re ates:	1	∐ Yes	2 X No Specify:			Specify: Whi	ce
5-0	22 82 33	Completed	15. Decedent' (Specify only highest	s Education		(Give I	kind of w	ual Occupation ork done during most of	workina	16b. Kir	nd of Business/In	dustry
21	within ene. then	npi	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. C	OO NOT	use retired)	3			
2	D D		12			H	lomen	naker	· · · · · · · · · · · · · · · · · · ·		Own Home	e
ă ng	ed at a b	Be	17. Father's Name (First, Middle, L						Name (First, Middle		,	
Maryland 21215-0036	2 should be 1 and Mental I is marked o aumatic eve	은	John Andre			10h Maille			11y Floy			Codel
Mai	12 st h and 7 is n traun		19a. Informant's Name/Relationsh		4 .			ss (Street and Number or				
as .	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Linda H. Chaka 20a. Method of Disposition	les / Dau		414/3 Place of Dispos		ss June Cour	t, Leonai		n MD 20 cation - City or To	
Baltimore,	permit. Pages 1 Department of H Important: if ite eny injury or ot		1 X Burial 2 ☐ Cremation		State	cemetery, crem	natory or	other place)			7.00	
Ħ	it. Parturant		4 ☐ Donation 5 ☐ Other (Sc 21. S par years Funeral Service L		St	. Georg						Maryland
Ba	Department of the partment of		Current Vive	6	. MOO			and Address of Facility				
	NE NE		Edward N. Brins 23a. Part1. Enter the disease, or					Hollywood R			own, MD	Approximate
			shock, or heart failure. List of immediate Cause (Final	only one cause on e	ach line.						0	Intervat Between Onset and Death
£ ==	Physician /Medical		disease or condition resulting in death)	a. #11	or as a consec		مرو	stic la	iden	Zerke	Lan C	ane -
4	Examiner			Due to	or as a consec	querice or.						
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	outed d ansit	Examin	Cause (Disease or injury that initiated events	c ====								
oʻ	an ar rial-t	Ě	resulting in death) Last	Due to (or as a consec	quence of):						
8760	cate be executed physician and the burial-transit	dicai	,	d								
9	ng pt	Med	IF FEMALE:							- 1		
Вох	death certific e attending p ed for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, out 1☐Live b	come of pregn		Ectopic	pregnancy		2	23d. Date of deliv Month	ery Day Year
	the deay the a	sic	1 ☐ Yes 2 M No 9 ☐ Unknown	4☐Pregn 9☐Unkno	ant at time of o	death 5	Other (s	specify)				, , , , , , , , , , , , , , , , , , , ,
P.O	that the d ed by the detached	Ph)	Part II. Other significant conditio	ne contributing to de	eath but not cor	culting in the un	edoch in a	course sweep in Rost I	22e Did	tobacco u	se contribute to t	the cause of death?
JS,	se us	by	Fact II. Other signmount conducto	ina continuuming to de	sain bai noi 14s	satisfy in the ur	idenying	Cause given in Fait i.				bably A Unknown
9	w requir been si should	etec							4			- / (
ec	2 55	ompieted							24a. Was		24b. Were auto prior to co death?	opsy findings available empletion of cause of
of Vital Records,	Th ate pag	S							1 ☐ Yes	2 No	1 Yes	2/1 No
Vit.	ıysician: Th iis certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other	Death Check only			
ō	hys this al dir	7	1 Yes 2 No	101		ER/Outpatient	1 3 🗆 E		g Home 5 ☐ Res			fy)
	ttending F death. tor: After the funera	- No	27. Manner of Death 1 ★Natural 5 □ Pending		th, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	now injury	y occurred	
isi	Attending r death.	icat	2 Accident investig	ot be 380 Place	ol Injuny - At h	iome, larm, stre			281 Location	Street and	d Number or Rus	al Route Number,
Division	l or Att after de Direct	Certification:	4 Homicide determi	ned 288. Flace buildi	ng, etc. (Speci	fy)	eet, racio	rry, onice	City or To			ar noble Number,
ا	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by		29a. Certifier 12 Certifying	Physician: To the	best of my kn	owledne death	OCCUITO	d at the time, date and pl	ace, and due to the	Cause(s)	and manner as	stated
)	24 h	edicai	(Check only 2 Medical E	xaminer: On the b	asis of examina	ation and/or inv	estigatio	n, in my opinion, death o	ccurred at the time,	date and	place, and due !	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	/			2	9c. License number		29d. Dat	e signed (Month,	Day, Year)
	- > - o		$\rightarrow V \cap A / A$	mot	WM-)		1)1428	···	2	-130	
			F F 12 1/ 4									/ A
		1	30. Name and address of person v	who completed caus	se of death (Ite	m 23a) (Tvne I	Print)	011	•		150	G
			30. Name and address of person v	TT M D								
	Sta	te	30. Name and address of person william D. Boyd 31. Date lifed (Month, Day, Year)	TT M D		5 Point						

			For Stata Registrar	case			and / Dep		t of H	lealth a	and M	ental Hy		006	056	16
			Decedent's Name (First, M.	liddle, Last)		··· .					2. Date of Dea	ath	Vans	3. Time o	f Death
	Physici /Medic		ANN V		PHILLI	PS						FEBRUA	RY5 "	2006	2:42	Рм
	Examin		4a. Fecility Name (If not instit	ution, give	street and nu	ımber)		4b. City,	Town, or	Location of	of Death		4c.	County of Deatl	1	
			SUNBRIDGE CA			,				KTON				CECIL		
	Funeral Director		5. Social Security Number 221-14-5124		x]M 2 X ∫F	7. Age (In ye	rs. last birthday, Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day JUL 4,	1916	9. Birti Co WILM	nplace (State untry) INGTON	or Foreign , DE
	show	2	Usuel Residence of Deceder 10a. State 10b. Co DE NE		TLE		City, Town or L								10d. Inside C	ity Limits
	28a-1	ect	10e. Street and Number					10f. Zip	Code				10a. Citi:	zen of What Co	untry?	
	with page 1	<u>a</u>	33 PIERSON	PL					1972	:0				USA		
36	u within 72 hours after death with the Maryland jiene. I then "neturel", or Items 23e or 28e-1 show It to Medical Evantinet must be rediffed at	by Funeral Director	11. Marital Status 1 Never Married 2	Married	12. Was Dec Armed F 1 Tes If Yes, G Year or I	2 No ive No	1 U.S. 13.		dent of H cify Cuba	ispanic Ori In, Mexicar		ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: W		
Maryland 21215-0036	within 72 hour ene. then "neturel in Medical E	Completed t	15. Dec (Specify only h Elementary/Secondary (0-	edent's Edu ighest grad	ucation de completed,		(Give	dent's Usu kind of wo DO NOT u	ork done d se retired	during mos	t of worki	ng		nd of Business/	industry	
2	filed w Hygier other th		8	(dla (aat)			HOM	LMAKE	.K	19 Moths	aria Nama	(First, Middle,		N HOME		
yland	e d a b	To Be		PETAN						LUC	ĹΑ	DEAN	IA.			
Nar	12 sho h and 7 is m		19a. Informant's Name/Rela			D A HOHER		ing Address						r Town, State, 2 • DE 19		
	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		EVELYN A 20a. Method of Disposition	PUP	TLLO	DAUGHT 20t	. Place of Disp	osition (Nai	me of			Date		cation - City or		
DO .	Pages nent of int: If Its ury or o		1 X Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ QM			State	cemetery, cre ATHEDRA	matory or o	other plac		FR 8	, 2006		LMINGTO		
Baltimore,	1 E E E	li	21. Signature of Firm, et Ser	11		10.								N FUNER		ES INC
ñ	Depar Depar Impo		1 hatalo	3-2c	heer							EWCASTL			110111	
760,	In policial American and American and American and American and American and American and American Ame	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Ener Uniderlying Cause (Disease or injury that intitated events resulting in death) Last	{	b. Due to	(or as a cons	equince of):	ATT	ery	di	sea	Se.			Onset and	alewes
O. Box 68	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t	1 Live	utcome of pre birth 2 □ F gnant at time on	etal death 3	□Ectopic p □ Other (s)		,			2	23d. Date of del Month	ivery Day	Year
rds, P.O.	quires that the de n signed by the a uld be detached t	by	Part II. Other significant go	nditions co	ontributing to わる	death but not	resulting in the	underlying	cause giv	en in Part I				ise contribute to □ No 3 □ Pr	\	death? Dinknown
I Records,		Completed												24b. Were au prior to death? 1 \(\sum \text{Yes}	completion of	
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to me examiner?		l lassital.				0.1			n (Check only o				
of	hys this al dii	To.	1 ☐ Yes 2 🕅 No 27. Manner of Death				28b. Time			4		me 5 Resident		6 □Other (Spe	cify)	
o	ding h. h. After funer	tlon	1 Matural 5 □ P	ending vestigation	(Mo	of Injury nth, Day Yeer	njury	M	28c. Injur Wor 1 □	k? Yes 2 □		204. 20001120	1011 111,01	, 0004.700		
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ C	ould not be termined	286. Plac	ee of Injury - A ding, etc. (Sp	t home, farm, s	treet, factor				28f. Location (City or Tox	Street an vn, State	nd Number or Ru	ıral Route Nui	mber,
	To the Hospitel or Atti within 24 hours after de To the Funeral Direct completely filled in by ti	edical C	29a. Certifier 1 Car (Check only 2 Med	tifying Phy lical Exam	inar: On the	ne best of my basis of exam nner stated.	knowledge, dea ination and/or i	th occurred	at the tir	me, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) date and	and manner as d place, and due	stated. to the cause	(s)
	To the within 2 To the complet	Me	29b. Signature and the of co	ertifier A					_	e number	72	0	- 1	te signed (Mont		
	5		30. Name and address of pe	rson who d	completed car	use of death (Item 23a) (Type	Print)	of-	(7)	2 R	916	Ma	$m \wedge$	2192	1
	Sta Regist		31. Date filed (Month, Day, FEB 0 7		32.	Registrar's Si	gnature	3100	XI.	516	ب, ر	CCA	VII	mD		1
	negisti	rai	1 50 0 1	2006	LUCE	75J JU	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 1933 8 2006 02 CLEMMIE CHAPPELL PERRY /Medical 4c. County of Death Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death **Examiner** Regional Medical Center Peninsula Salisbury Wignuce If Under 1 Year | If Under 24 Hrs. 6. Sex Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗙 F Director 401-44-7351 Jan. 18, 1930 Tennessee Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits 28a-f shov 1 Yes 2 □ No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 Completed by Funeral 627 Decatur Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No tf Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) House of God College (1-4or 5+) other then Hygiene. Pastor Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental marked Sallie Standard P Colonel Franklin Boaz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 627 Decatur Avenue - Salisbury, Maryland 21804
Date of Disposition (Name of Date 20c. Location - City or Town, State Linda Mosely/dau/hter item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Depertment of important: If it any injury or o 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Green Acres Mem. Pk.02/14/2006 Salisbury, Maryland 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Signature CHAPEL JOLLEY MEMORIAL 23a. Part 1. Enter the disease, or commodation shart caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** INCEPHALOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ★ No RENAL 24a. Was an autopsy performe 2/2 No SEIZURE DISIRDER 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Japital C. 4 hours after dea. The Infector: After the fundamental presents of the total 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Tortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2

411

17-10

Clemmic

Registrar

29b. Signature and title of certifier

M.THMMAANAMO 31. Date filed (Month, Day, Year) FEB 1 3 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Aégistrar's Signature

DHMH 17 Rev 1/2001

D-0060515

614B EASTERN SHURE DA SALISBURY MD 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland	-	rtment of H tificate of L		Re	eg. No. 006	05618
	Physici /Medic		Decedent's Name (First, Middle, Last) Thomas	Edward Power	s Jr	•		2. Date of Deat Month February 1	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s Prince George's Genera	al Hospital		4b. City, Town, or Cheverly	7		4c. County of Dea Prince Geor	ge's
	Funeral Director		5. Social Security Number 216-06-9283 Usual Residence of Decedent	7. Age (In yrs. las M 2□F 39	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, August 10,	9. Bit	thplace (State or Foreign ountry) Maryland
	Maryland f show	tor	10a. State 10b. County Maryland Prince George		Town or Loc Strict	eation Heights				10d. Inside City Limits 1 ☐ Yes 2 No
	an or 28a	I Director	10e. Street and Number 6908 Foster Street			10f. Zip Code)747	1	0g. Citizen of What C	ountry?
36	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "naturel", or Items 23a or 28a-f show event. The Madical Ever ill withrest to indiffical at	by Funeral	11. Marital Status 1	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 KNo If Yes, Give Year or Dates:	i	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	within 72 hou one. then "nature is Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	lent's Usual Occupa kind of work done of DO NOT use retired Disabled	ation during most of wor l)	rking	16b. Kind of Business	/Industry
Maryland 2	be filed tal Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, Last) Thomas Edward Powers S	Sr.		DISABLEG		ne (First, Middle, 1 a Carole Ha	Maiden Sumame)	
lary	2 should and Men is marke	-	19a. Informant's Name/Relationship (Typ						City or Town, State,	
Baltimore, N	Pages 1 and 2 should hent of Health and Men int: If item 27 is marke iry or other treumatic		Loretta C. Powers / I 20a. Method of Disposition 1 XXBurial 2 Cremation 3 CR 14 Donation 5 Other (Specify)	emoval from State	ce of Dispos netery, cren	Foster Stre sition (Name of natory or other plac n Cemetery	:e)		Maryland 2 20c. Location - City o Clinton, Ma	
Baltii	permit, Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service License	Swann		Name and Addres	Ge		las Funeral bryland 20	Home P.A. 745
	rhysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	mi	er the mode of dyin	g, such as cardia	o respiratory arr	est,	Approximate Interval Between Onset and Death
68760, <	ificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. It is the distribution of the cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):) Pas	lsen	·		
.O. Box 68	death certifi e attending id for use as	hysiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	leath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	alivery Day Year
Δ	og og	by P	Part II. Other significant conditions cor	ntributing to death but not result	ting in the ur	nderlying cause giv	en in Part I.	23e. Did to		to the cause of death? Probably 4 Unknown
Vital Records,	e law	Completed						24a. Was a autops perfor 1 ☐ Yes	prior to med2 death?	utopsy findings available completion of cause of s
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		Oth	00	ath (Check only or		
ð	ling After uner	atlon: To	1 Yes 2 No 27 Manner of leath 1 Natural 5 Pending 2 Accident investigation	. 1 Inpatient 2 ⊟E	R/Outpatien 28b. Tîme of Injury	28c. Injun	y at		ence 6 □ Other (<i>Sp</i> ow injury occurred	ecity)
Division	i Pire	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,
	Hospitel	Medical		sician: To the best of my know ner: On the basis of examination and manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (Mor	nth, Day Year)
			30. Name and address of person who co	appleted cause of death (Item 2	23a) (Type,	Print)	5031	5	2/14/	106
	3		James () 31. Date-Hed (Month, Day, Year)	9 HVRNS 32. Begistrar's Signatu	3001	HUSPIT	AL DA	e CHEV	revly M	1020485
	Sta Registi		FFR 2 4 70	06 A	1 de	catil				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2006 Lester William Price February 7:34 PM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Washington Julia Manor Nursing Home Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 12,1937 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Hours Months 170 M 2□ F 68 MD Director 219**-**34-6161 Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health end Mentel Hygiene. Important: If Item 27 is marked other than "nature!, or heme 23e or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐XNo Funeral Director **Allegany** Little Orleans 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 21766 **USA** 10730 John Price Road 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married ☐ Yes 2 No f Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 21 No Specify: Specify. Completed by 3 Widowed 4 Divorced Yeer or Dates. White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Aircraft Manufacture Processer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be John Price Lola Creek 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3322 Resley Road Hancock, MD 21750 Geneva Diehl/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt.Olivet Presbyterian 02/16/06 Hancock, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner edical Certification: To Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? hes 1 🗌 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 25 No 1 Yes this eral Director: After thi filled in by the funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 5 Pending 1 (ZNatural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide within 24 hours e To the Funeral D 29a. Certifier 1😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 02/13/06 062323 200 30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 0 M.D. 1126 Opal Court Hagerstown, MD 21740 Farid Murshed, 32. Registrer's Signature

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

2006 4

			1 - For State Registrar		State	of Maryla	•			lealth a <i>Death</i>	and M	ental Hyو ۶	giene Reg. No.	006	05620
			1. Decedent's Name (First, Mic	dle, Last)								2. Date of Dea Month	ath Day	Year	3. Time of Death
П	Physicia /Medic		Robert Keste	r Ril	Ley, S	Sr.						Februar	y 1	2006	8:40 P ^M
Į.	Examin		4a. Facility Name (If not institut	ion, give s	treet and nu	ımber)		4b. Cit	y, Town, o	r Location o	of Death		4c.	County of Deal	h
			706 Appomatt		ad W.					onvil				Anne A	
	Funeral		5. Social Security Number	6. Sex	M 2□F		. last birthday) Yrs.	Month:	er 1 Year Days	If Under	Min.	8. Date of Birtl (Month, Day	h v, Year)		holace (State or Foreign
	Director		215–32–5809 Usuel Residence of Decedent			74	113.		1			1-22-1	932	Mai	ryland
	and and		10a. State 10b. Cour	ty		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	Mary feb	ō	Maryland Anne	Arun	ıdel		Davids	onvi	lle						1 ☐ Yes 2 📉 No
	the roull	rec	10e. Street and Number					10f. Z	ip Code				10g. Citi	zen of What Co	ountry?
	3a or	<u>=</u>	706 Appomatto	x Roa	ıd W.			2	1035					USA	
	ms 2	Funeral Director	11. Marital Status			cedent Ever in orces?	U.S. 13.	Was Dec	edent of H	lispanic Ori	igin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	
9	after or ite	Ē	1 ☐ Never Married 2 🛣 M		1 Tes	2 [Ž (No			2 X No	Specify:	1, FUBILO I	nicari, etc.)		Specify: _	e, etc.
2	ral', c	d by	3 Widowed 4 Divorc	ed	Year or I	Dates:		103	24110	Specify.				Specify. V	Vhite
21215-0036	illed within 72 hours after death with the Maryland Hyglene. the then "netural", or items 23s or 28s-f ehow int, the Medical Evaniner must be notified at	Completed	15. Deced (Specify only high	ent's Educ est grade	ation completed)	16a. Dece (Give	dent's Us	ual Occup vork done	ation during mos. d)	t of workir	ng	16b. Ki	nd of Business	Industry
2	hen hen	ם	Elementary/Secondary (0-12) 1		(1-4or 5+)							For	lowal Co	or rozmont
	iled v 1ygie thert	ပိ	17. Father's Name (First, Midd	e Last)	year) P	ioto	graph		er's Name	(First, Middle,			overnment
Maryland	9 7 5 P	Be	John W. R							R	uth I	Morelan	d		
2	eges 1 end 2 should b nt of Heelth and Ment t: If Item 27 ie marke y or other treumatic e	မှ	19a. Informant's Name/Relation		e, Print)		19b. Maili	ng Addre	ss (Street					r Town, State, 2	Zip Code)
Z Z	end 2 seelth ar n 27 io		Margaret H. R	ilou/	Wife		706	Anno	vatte	v Foa	A W	David	conv	dilo N	m 21035
ō,	f Hee f Hee item		20a. Method of Disposition	-		20b.	Place of Dispo	osition (A	ame of	ca)	D	ate	20c. Lo	cation - City or	1D 21035 Town, State
ê E	Peges nent of int: If it iry or o		1 X Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		moval from		. Zion							nian, Ma	
Baltimore,	permit. Pege Department Important: If any njury o	-	21. Signatura f Funeral Servi												eral Home
ñ	Page 1		Mobile	M	il_							_			MD 21037
			23a. Part1. Enter the disease, shock, or heart failure. L	or complic	ations that	caused the dea	ath. Do not en	ter the m	ode of dyir	ng, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition	,	5	POSIS	_								Onset and Death
4	/Medical		resulting in death)	C a.	Due to	(or as a conse	quence of):			£					21.17(17(3)
	Examiner		Supportingly list correlations	ь	D	neum	onla								2 months.
	יון ס	Examiner	Sequentially list nor ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	Due to	(or as a conse	quence of):								
	and and trans	cam	that initiated events resulting in death) Last	c.	- Due te	(or as a conse	auana at):						_		
60,	te be executed ysicien and le buriai-transit	E	,	ı	Que to	(OI as a CONSC	quarica or).								
58760,	m 55	edical		d.			<u> </u>								
_			IF FEMALE:	23	Bc. If yes, or	utcome of pregi	nancy							23d. Date of de	livery
Вох	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?			birth 2 ☐ Fe nant at time of]Ectopic] Other (pregnancy specify) _	У				Month	Day Year
o.	at the de by the a tached	lys	1 Yes 2 No 9 Unknown		9□ Unki	nown						_			34
<u> </u>	The law requires that the death certified has been signed by the attending page 2 should be detached for use a	by Pi	Part II. Other significant cond	itions con	tributing to	death but not re	sulling in the u	nderlying	cause giv	ven in Part I		23e. Did to	obacco u	ise contribute to	the cause of death?
5	w requires that been signed to should be deta											101	es 2	XNo 3□P	robably 4 Unknown
ပ္ပ	s bee	Set										24a. Was		24b. Were at	utopsy findings available completion of cause of
Ä	: The law cete has	Completed										autop perfo	rmed? 2 X No	death?	2 No
a		BeC	25. Was case referred to medi	cal						26. Place	of Death	(Check only o		1	
>	nysic nis ce direc	To E	examiner? 1 🗆 Yes 2 🗙 No	H	ospital:	Inpatient 2	☐ ER/Outpatie	nt 3 🗆 1	DOA Ott	ner: 4□Nu	ursing Hor	ne Resid	dence	6 ☐Other (Spe	cify)
0	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pen	dina	28a. Date (Mo	of Injury nth, Day Year)	28b. Time of Injury	f	28c. Injui Wo			28d. Describe h	now injur	y occurred	
0	ttendii death. ctor: Al / the fu	atle	2 Accident inve	stigation				М		Yes 2					
Division of Vital Records,	or Attending Physician: ifer death. Sirector: After this certifici	Certification:		mined	28e. Plac	e of Injury - At ding, etc. <i>(Spe</i> c	home, farm, st cify)	reet, fact	ory, office		1	28f. Location (S City or Tox	Street an vn, State	d Number or Ri)	ural Route Number,
	urs of urs of ural D					or pouge top occur.	contact days	la constant	chorner -	Carlo Barbara	M attended	and the same of	and the second	and determine	of the latest of
	To the Hospital or Atlendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fu	Medical			er: On the									and manner and place, and due	e to the cause(s)
	o the ithin (o the omple	Me	29b. Signature and title of cert	fier	and ma	Stateu.		2	9c. Licens	se number			29d. Dat	e signed (Mont	h, Day, Year)
	⊢≯⊢ŏ				Jul				DO	577L	15		Ephi	rilaria	2 200/-
			30. Name and address of pers	on who co	npleted car	use of death (Its	em 23a) (Type	Print)		166	, ,		CD		0,2000
				_	dma	- 0	: 1	o D	eter	KE H	huu	Suite	2 40	X AV	3,2006 MO 21401
	Sta		31. Date filed (Month, Day, Ye	ar)	32	Registrar's Sign				1)				MD 21401
	Registr	0.12	CED A	7 28AA	4 4 4		ALC. The	A 400	A .						

			For State Registrar	State of Mar	yland /	-	artment of				ene 2006	05621
V _S ⁿ	Discount of the second	11	1. Decedent's Name (First, Middle, La							2. Date of Death Month		3. Time of Death
	Physici /Medic		Clarice M. R			1				Feb.	4, 20	006 9:20a ^M
	Examir	er	4a. Facility Name (If not institution, giv 1437 Old Anna		d.		4b. City, Town,	or Location			4c. County of (ne Arundel
in a	Funeral		5. Social Security Number 6. S	ex 7. Age ('In yrs. last		If Under 1 Yea Months Days		r 24 Hrs. Min.	8. Date of Birth (Month, Day,	(ear) 9.	Birthplace (State or Foreign Country)
	Director		214-12-9244 Usual Residence of Decedent	M 2(AF	87	Yrs.				Jul. 24,		MD
3	Nand Now		10a. State 10b. County		Oc. City, To	own or Lo						10d. Inside City Limits
	death with the Maryland ms 23a or 28e-f show rmust be rotified at	ctor	MD Anne	Arundel			Ar	nold				1 ☐ Yes 2X No
10.	or 28	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wha	
1	ss 23s	erai	1437 Old Annapol	is Road 12. Was Decedent Eve	er in II S	13 1		21012	rigin? (Spe	ody Yes or No-		JSA American Indian,
_ 3	be lied within 7.2 hours after beain with the marylar lat Hygiene. Ital Hygiene. d other then "natural", or itams 23a or 28e-f show event, the Medical Examinar must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	61 111 0.3.		Vas Decedent of f Yes, specify Cu I ☐ Yes 2 ☑ No			Rican, etc.)		White, etc. White
ာ	natur	Completed	15. Decedent's E (Specify only highest gra		10	6a. Deced	lent's Usual Occi	upation e during mo	st of worki	19	6b. Kind of Busin	ess/Industry
2	Hygiene. Hygiene. other then "ne: ent, the Medic	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		life. L	DO NOT use retir	ed)			77.	
20	Hygie Sther I		17. Father's Name (First, Middle, Last				Homen		ner's Name	(First, Middle, M		ome
an i	snould be nd Mental I marked o imatic eve	To Be	Otto Schmidt					Lol	a Sap	pington		
Maryland 21215-0036	of Health and Ment of Health and Ment litem 27 is marked rother traumatic		19a. Informant's Name/Relationship (* * * * * * * * * * * * * * * * * * * *			•			l Route Number,	•	
_	rand dealth sm 27 sher tr		Bonnie L. Seidel 20a. Method of Disposition	mann/Daught			/ SW Mad sition (Name of	ıera			Lucie, Oc. Location - Cit	FL 34953
	nent int: I		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	ceme	n Hav	ren Ceme	tery	Feb.	10, 006	Glen Bu	rnie, MD
Ra	Departr Departr Importe any inju		21. Sign ture of Fune al Service Licer	All W	1	B 4	Name and Add arranco 95 Gov.	* Son	is, P.	A. Sever	na Park na Park	Funeral Home MD 21146
1 3 20			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	e death. D							Approximate Interval Between
	hysician	1.1	Immediate Cause (Final disease or condition	a	Pa	vv	14501	~ · · · ·	~			Onset and Death
111	/Medical Examiner		resulting in death)	Due to (or as a c								
	e The .	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequenc	ce of):						
0	outen nd ransit	Examiner	cause. Enter Underlying Cause (Disease or infury that initiated events	c								
Ç,	cale be execute physicien and the burial-trans		resulting in death) Last	Due to (or as a o	consequenc	ce of):						
09/80	physic physic the b	dicai	•	d								
Вох	attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23d. Date o	f delivery
o.	rife faw requires that the death centificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ → 10 9 ☐ Unknown	1 Live birth 2 4 Pregnant at tin 9 Unknown			Ectopic pregnan Other (specify)	cy			Month	Day Year
, S	igned be det	þ	Part II. Dther significant conditions	ontributing to death but i	not resultin	g in the ur	nderlying cause g	iven in Part	1.			ite to the cause of death?
ord	should t	eted								1 Tes	; 2 □ No 3(Probably 4 Unknown
		Completed								24a. Was an autopsy perform	ed? prio	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
Vital	this certificateral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	-57.50			thor		(Check only one		
	ter this	7: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Y		Outpatien b. Time of	TOLIDOA	4 🗆 1		ne 5 Aesider 28d. Describe hov		(Specify)
lou	£ \$ 5	atio	1	1	rear)	Iniury		ork?]Yes 2[□No			
DIVISION	s after death	Certification:	3 Surcide 6 Could not b 4 Homicide determined	28e. Płace of Injury building, etc. (/ - At home (Specify)	, farm, str	eet, factory, office	9		28f. Location (Stre City or Town,	eet and Number o State)	or Rural Route Number,
Too D	within 24 hours aft To the Funeral Di completely filled in	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exer	ysician: To the best of on niner: On the basis of ex and manner state	xamination	dge, death and/or inv	occurred at the restigation, in my	time, date a opinion, de	and place, a	and due to the car ed at the time, da	use(s) and manne e and place, and	er as stated. I due to the cause(s)
T	within 2 To the complet	Me	29b. Signature and title of certifier				29c. Lice	nse number		29		Month, Day, Year)
			25 Chac	nu ->	WL	>	0	169	64		2-	6-06
			30. Name and address of person who		th (Item 23		Print)	H	٧./	Armo	w Di	· B 21012
	Sta		31. Date filed (Month, Day, Year)	32. Raistrar's	s Signature		1.0		- 7		-	
1	Registr	ar	FEB 0 8	ZUUD	N S	P 16						

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** FEBRUARY 2006 8:45AM DOROTHY L. RENAUT /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner EASTON TALBOT 6910 TRAVELERS REST CIRCLE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2**X** F MAY 10 1921 MISSOURI 84 Director 324-16-8597 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 7 is marked other then "naturel", or items 23e or 28e-f show treumatic event, II a Medical Examiner must be notified at 1 ☐ Yes 2 No Director EASTON TALBOT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21601 6910 TRAVELERS REST CIRCLE IISA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after □Yes 2**X** No Yes, G<u>i</u>ve 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: WHITE à 3X Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 shoutd be filed within 7 and Mental Hygiene.
7 is marked other then ". Elementary/Secondary (0-12) College (1-4or 5+) RESTAURANT/MARINA PROPRIETOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ANNABELLE TOMILSON RUSSELL HURST 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) iges 1 and 2 so it of Health an PO BOX 1564, SOLOMONS, MD 20668 KIMBERLY R. PEARL/PER. REP. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Depritment of H Importent: If ited any injury or oth CHESAPEAKE CREMATION CTR. 2/8/2006 STEVENSVILLE, MD `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee S, HELFENBEIN & NEWNAM FUNERAL HOME PA FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 S. HARRISON ST EASTON, MD 21601 DHN R. MERIEROA Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 enter the mode of dving, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list modifies if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit be executed consequence of) attending physician Box 68760 Physician/Medical as the l IF FEMALE: esr 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Po in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. the a 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 TYes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 12551W certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3 DOA Sitt 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ie Hospitei o 124 hours afi e Funerel Di 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated the To the within ? 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certiful 8 0 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANCHEZ, M.D. 508 IDLEWILD AVE. EASTON, MD 21601 ROBERT B. 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of I		, ,	giene 1000	5 05623
	Physici	an	Decedent's Name (First, Mide					2. Date of Dea Month	Dav	3. Time of Death
	/Medic Examir		4a. Facility Name (If not instituti 408B GOLDSBOR				or Location of De	FEBRUAI	4c. County of	006 12:55PM M of Death LBOT
	Funeral Director		5. Social Security Number 150-09-0972		Age (In yrs. last birthday 90 Yrs.		If Under 24 H	in. (Month, Day	7, Year) 3, 1915	Birthplace (State or Foreign Country) NEW JERSEY
	pu 🔾		Usual Residence of Decedent 10a. State 10b. Count	h.	10c. City, Town or L	ocation				10d. Inside City Limits
	Maryla f sho	ō	1.0	BOT	EASTO					1 ▼ Yes 2 □ No
	r 28a-	Director	10e. Street and Number	1001	12310	10f. Zip Code			10g. Citizen of W	hat Country?
	th with	alD	408B GOLDSBO	DROUGH ST.		2	21601			USA
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "netural", or items 23e or 28a-f show other treumatic event, the Medical Eventre fruit Le notified at	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 X Widowed 4 Divorce	If Vac Civa	□No	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ▼ No		(Specify Yes or No- erto Rican, etc.)	14. Race Black Specify:	- American Indian, c, White, etc. WHITE
21215-0036	within 72 ho iene. then "netur	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education lest grade completed)	(Giv	edent's Usual Occu e kind of work done DO NOT use retire	during most of v	vorking	16b. Kind of Bus	siness/Industry
121	led wi lygien her th		12	5	EX	ECUTIVE	40 14-11-1-1	1 (P** 1 8 d-4)-		VERNMENT
Maryland	s should be filed within and Mental Hygiene. s marked other then "	To Be	17. Father's Name (First, Middle JAMES H. REY	NOLDS				lame (First, Middle, EN MARIE		a)
Mar	d 2 sho th and 7 Is mu treuma		19a. Informant's Name/Relation HOPE R. HARR					Rural Route Numbe	-	
	of Health of Health litem 27 I		20a. Method of Disposition	ENGTON, DAGGE	20b. Place of Disp	osition (Name of	1	Date		City or Town, State
9			1 ☐ Burial 2 X Cremation 1 ☐ Donation 5 ☐ Other		ite	matory or other pla	· .	2/9/2006	STEVENS	SVILLE, MD
Baltimore,	permit. Page Department of Importent: If any Injury or once.		21. Signature of Funeral Service	e Licensee Ostrowski C	CCO F	2. Name and Addre	ess of Facility IELFENBE		AM FUNER	RAL HOME PA
8760,	Physician /Medical Examiner physician and physician and the prujetransit	ical Examiner	23a. Part1. Enter the disease, shock, or heart failure. Li. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ab	sed the death. Do not er					Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 t at time of death 5	□Ectopic pregnand □ Other (specify) _	у		23d. Date Mon	e of delivery th Day Year
	uires that signed by Id be deta	by	Part II. Other significant condi		h but not resulting in the	underlying cause gr	ven in Part I.			bute to the cause of death? 3 Probably 4 Unknown
il Records,		Completed	CHONICH	obstructi	'vé pula	oNAIZ	Dilonic	24a. Was autop perior 1 \(\text{Yes}	med? pr	Vere autopsy findings available for to completion of cause of eath? ☐ Yes 2 ☐ No
of Vital	Physician: The this certificate har director, page	Be	25. Was case referred to medic examiner?	Hospital		O#		Death (Check only or		
of	F = E	J: To	1 ☐ Yes 2 € No 27. Manner of Death	28a. Date of I	njury 28b. Time	SIL 3 DOA	4 🗆 Marianié	Home 5 Resid	ence 6 Othe	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune.	Certification:	3 Suicide 6 □ Could	ting (Month, tigation d not be mined 28e. Place of	Injury - At home, farm, s etc. (Specify)	M 1	Yes 2 ☐ No	28f. Location (S City or Tow		or or Rural Route Number,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ledical Ce	29a. Certifier 1 Certify (Check only one)	ring Physician: To the beat Examiner: On the basis	s of examination and/or i	th occurred at the tinvestigation, in my	ime, date and pla opinion, death oc	ace, and due to the occurred at the time, o	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
	To the within Fo the comple	Med	29b. Signature and title of certif		7/11	29c. Licen	se number		29d. Date signed	(Month, Day, Year)
			1 / made	1/1/	anton M	DD	31466	5	2/6,	106
	7-04		30. Name and address of perso				T4 070	VD 0160	12/	- Ad
-	300				M.D. 503 CY		. EASTON	, MD 2160	1	
	Sta Registr		31. Date filed (APPB)any	2006	Strains Signature	od.				

			1- For State of Maryland / Dep	eartment of Health and Me ertificate of Death		ene 0 0 6	05624
	L		Decedent's Name (First, Middle, Last)	2	. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Richard Hobson Russ, Jr.	F	ebruary		1:14 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th
			Manor Care Bethesda	Bethesda		Montgome	
	Funeral		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday 1 M 2 □ F 7. Yrs.	Months Days Hours Min.	Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign puntry)
	Director		579–24–2687 79 Usual Residence of Decedent	M	arch 31	, 1926 Was	shington, DC
	land ow		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary -1 sh	ţ	MD Anne Arundel Co. Lothian				1 ☐ Yes 2 X No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	ountry?
	h witi	ai D	3 Patuxent Mobile Estates	20711		U.S.A.	
	deat	ner		. Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No-	14. Race - Ame Black, Whit	
ဖွ	or Its	Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☐ No Specify:	Jan, 010.7	Specify: Wh	
8	72 hours after death with the Maryland naturel', or Iteme 23a or 28a-f show dissal Examires must be notified at	Completed by Funeral	3 XI Widowed 4 Divorced Year or Dates:				
5	"nat	lete	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	1	6b. Kind of Business	Industry
12	within ene.	m C	Elementary/Secondary (0-12) College (1-4or 5+)	ibit Specialist		Federal G	www.
d 2	filed Hygi ther	Ö	17. Father's Name (First, Middle, Last)	18. Mother's Name (overmment
lan	td be entat ked c	To Be	Richard Hobson Russ, Sr.	Alice R.	Canada		
Maryland 21215-0036	shound M	-		ling Address (Street and Number or Rural I			Zip Code)
	and 2 alth a 127 i		George W. Russ (Son) 1732	5 Hughes Road, Pool	esville	. Maryland	1 20837
ore	of He of He fiter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition	position (Name of ematory or other place) Februa		0c. Location - City or	Town, State
Ĕ	Pag nent ent: f ury o		`4 Donation 5 Other (Specify) Arlingto			rlington,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or iteme 23a or 28a-1 show any injury or other treumatic event. If a Madical Exertiner mast be notified at once.			22. Name and Address of Facility Lee 125 Southern Maryla			
	W.		23a. Part1. Enter the disease, of complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or r	espiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	e to thinie			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):	-1 6			
	Examiner		Sequentially list conditions, b.	inlin			
	be sit	ine	if any, leading to immediate Due to (or as a consequence of): cause, Disease or injury				
	and I-tran	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of);				
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687	death certificate be executed e attending physician and id for use as the burial-transit	edic	0.				
ŏ	death certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectoria programov		23d. Date of de	livery
B		by Physician/Me	1 Yes 2 No	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
P.O.	that the de ned by the a detached f	hys	9 CONKNOWN				
Ś	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to	
ord	Ben s	ted			1 🗆 Yes	s 21926No 3□P	robably 4 □Unknown
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E H	T ate	Cor			perform 1 Yes 2	ed? death?	2 3 40
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (
of	Phys rthis ral dii	7	1 Yes 2 No Prospital: 1 Inpatient 2 ER/Outpatie	ant 3LI DOA 4SPAUISING HOME		nce 6 Other (Spe	cify)
on	ding th. After fune	tion	1 Matural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at 28- Work? M 1 ☐ Yes 2 ☐ No	a. Doson.bo	a mjary occurred	
Division of Vital	Attending r death. actor: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	treet, factory, office 28		eet and Number or R	ural Route Number,
á	al or A s after al Direct	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Physicien: within 24 hours atter death. To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certiflier (Check only 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in	ith occurred at the time, date and place, annvestigation, in my opinion, death occurred	d due to the car at the time, da	use(s) and manner atte and place, and due	s stated.
	thin 2, the I mplet	Medical	one) and manner stated. 29b. Signature and title of certifier.	29c. License number		d. Date signed (Mon	
	T w			10 00057/2			
,			30. Name and address of person who completed cause of death (Item 23a) (Type	,,000	1	-(-/	U 12
	15+1			e, Bethesda, Maryla	nd 2081	7	
	Sta	te					
	Registr	ar	FEB - 6 2006	Hower			

			For	State of Marylan	d / Depa	artment of H	lealth and	d Mental Hygi	_	0562) 5			
			For State Registrar		Ce	rtificate of L	Death		g. No.					
	Physicia	an	Decedent's Name (First, Middle, Last) Total	-	ъ.			2. Date of Death Month	Day Year	3. Time of D				
	/Medic		John	F	Re	ginaldi	1 11	Februar		5:15	ΑM			
4	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or Freder		eatn	4c. County of Death					
		April 1	Frederick Memoria 5. Social Security Number 6. Sex		last birthday)		I CK		9. Birth	place (State or	Foreign			
\$.	Funeral Director			M 2□F 81	Yrs.	Months Days	Hours M	Apr. 25,	1924 Mary	Tand				
	iand bw		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City	Limits			
	Mary -f eh fied	to	Maryland Frederic	k Fr	ederio	k				1 ☐ Yes 2	≥ XNo			
	be filed within 72 hours after death with the Maryland nial Hygiene. Be other then "naturel", or itema 23a or 28e-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 5993 White Flint D	rive		10f. Zip Code 2170	02	10	g. Citizen of What Cou USA	untry?				
	death	era	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H	ispanic Origin?	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Amer					
9	after or iter	Ţ	1 Never Married 2 Marned	Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give T.II.I				uerto Rican, etc.)	Black, White	, etc.				
93	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: WW	II	1 ☐ Yes 2 ₹ No	Specify:		Specify: Wh	ite				
5	72 h 'natu	ete	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of	working 1	6b. Kind of Business/l	ndustry				
121	e filed within al Hygiene. I other then '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		igeration,	_	1	U.S. Gove	rnment				
d 2	filed Hygie Sther		17. Father's Name (First, Middle, Last)			801401011,		Name (First, Middle, M						
Maryland 21215-0036	2 should be and Mental ie marked o	To Be	Frank	Reginal			Maria		Levi					
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ď.	s 1 and 3 f Health item 27 other tri		Paul Reginaldi/Son					ive, Frede	TICK, MD Z Oc. Location - City or 1					
סַ	ages nt of in		1XXBurial 2 ☐ Cremation 3 ☐ R	emoval from State		osition (Name of matory or other place								
Baltimore,	iit. Partme		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		t Have	en Mem. Ga	ards: 2/	11/2006 F	rederick,	MD.				
Ba	permit. Pages 1 Department of F important: if ite eny injury or ot		Bes 6MC	0				tauffer Fu Pike, Fre						
	Talifal Inc.		23a. Paril Enter the disease, or complishock, or heart failure. List only on	cations that caused the deat						Approximate				
	Physician		Immediate Cause (Final disease or condition	To Calle	1 0		/			Onset and De	eath			
Sec.	/Medical		mmediate Cause (Final fisease or condition esulting in death) a. Due to (or as a consequence ol):											
	Examiner		Conventially list conditions		0	,								
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	wenee of):									
	te be executed ysician and te burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	i.										
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687	icate t	dlcai												
9 x	death certificate e attending phy d for use as the	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregna	incv				23d. Date of deli	1001				
Box	atten for us	ian	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	☐Ectopic pregnancy ☐ Other (specify)			Month	,	ear .			
0	0 00 2	isic	1 Yes 2 No	9□ Unknown	00.11									
Ω.	that the		Part II. Other significant conditions cor	tributing to death but not res	ulting in the u	inderlying cause give	en in Part I	23e. Did tob	acco use contribute to	the cause of de	ath?			
Records,	law requires es been sign 2 should be	ed by	adenocarano	mir of flun	15 Co	nonie a	les Free	tur 1X Yes	s 2□No 3□Pro	obably 4 Ur	iknown			
000	aw requii as been s 2 should	pieted	pulmanan de	incore ?	1000	For Can	desnus	24a. Was an	24b. Were au	topsy findings av	vailable			
Ä	0 4 9	Com	dichet	mamin		Georgia Commission	00	autopsy perform	ed? death?	2□ No	756 UI			
Vital	ysician; Th is certificete director, pag	BeC	25. Was case referred to medical examiner?	inamina.			26. Place of	Death Check only one						
of V	d is	To E	1 ☐ Yes 2 XNo	lospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Oth	er: 4 ☐ Nursin	ng Home 5 Resider	nce 6 Other (Spec	ufy)				
	ding Ph th. After th funeral		27. Manner of Death ↑ Natural 5 □ Pending	28a. Tate of Injury (Month, Day Year)	28b. Time o	Wor		28d. Describe how	w injury occurred					
sio	Attending r death.	cati	Accident investigation 3 Suicide 6 Could not be				Yes 2 □No							
Division		Certification:	4 Homicide determined	28e. Ptace of Injury - At he building, etc. (Specif.	ome, Iarm, st y)	reet, factory, office		City or Town,	eet and Number or Ru . State)	rai Houte Numb	er,			
	To the Hospitei or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	eicien: To the best of my line ner: On the basis of examina and manner stated.	wledge dos	th occurred at the tin evestigation, in my o	ne date and pl pinion, death o	isce and due to the na occurred at the time, da	usa(s) or dimannar as te and place, and due	stated to the cause(s)				
	To the I within 2 To the I complet	Med	29b. Signature and little of pertifier		. /	29c. Licens	e number	29	d. Date signed (Monti	n, Day, Year)				
	N, 0 - 2 -		1///	Chapter	K mi	DZ	518	3 F	Pres	E 20	06			
•	* WY		30. Name and address of pe sor who co	ompleted cause of death (Item	n 23a) (Type,	Print)	- / 0	1 12	i many		- 63			
	2,		H11 J-A	track tel	(*	300 L	vest	9th 5/1	ebruary	derick	11/2			
1	Sta Registi		31. Date liled (Month, FEB 0 9	32. Registrar's Signa	ture	how								

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of I	Marylar		artmen rtificat			and M	lental Hyg	giene	6	05626
	Physici	an	1. Decedent's Name (First, Middle, Last)			-				Date of Dea Month	Day	Year	3. Time of Death
	/Medic	- 3		Robert							Februar			3:10 P ^M
	Examin	ier	4a. Facility Name (If not institution, give St. Mary s Nursi:					nard:	Location o	of Death		4c. County o		
	Funeral		5. Social Security Number 6. Se			last birthday)	II Under	r 1 Year	If Under		8. Date of Birt	St. M		place (State or Foreign
	Director		579-62-3685]M 2□ X F		59 Yrs.	Months	Days	Hours	Min.	(Month, Da) 2-27-1			ington, DC
	D		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	oation							0d. Inside City Limits
	faryia shor	5		,									'	1 K Yes 2 □ No
	28e-1	rect	MD St. Ma:	ry's	_ L	eonard	10f. Zip	Code				10g. Citizen of W	hat Cour	ntry?
	3s or		21585 Peabody St	reet				650				United	Stat	es
	death	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U	I.S. 13.			spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)			can Indian,
ထ္ထ	or Its	F	1 Never Married 2 Married	1 Tes 2	⊠ No	1	1 🗌 Yes		Specify:	i, r deito	riican, etc.,	Specify:		etc.
8	72 hours after death with the Maryland naturel, or Items 23a or 28e-1 show digal Examiner must be notified at	d by	3 ☐ Widowed 4 🛣 Divorced	Year or Date	os:							16b. Kind of Bus	Whi	
7	in 72 in 8	Completed	15. Decedent's Edu (Specify only highest grad	le completed)		16a. Dece (Give	kind of wo	ai Occupa ork done d se retired	ation <i>furing m</i> osi)	t of work	ng	160. Kind of Bus	iness/in	austry
212	r thar	E O	Elementary/Secondary (0-12)	College (1-4 5	or 5+)	Techno						Federal	. Gov	vernment
ğ	e file al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)									Maiden Sumame		
<u>ylaı</u>	Menta Menta Brked	70	Joseph Milton 0'	Brien					Eli:	zabe	th Mary	Bray		
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Examiner must be notified at Apple. Dece.	li	19a. Informant's Name/Relationship (T)	/ρe, Print)		1	-					r, City or Town, S		
e)	1 end Health		Sharon O'Brien/S: 20a. Method of Disposition	ister	20h I	Place of Dispo			ice D		, SIIVE	r Spring		
Baltimore,	ages nt of th		1 ☐ Burial 2 X Cremation 3 ☐ F		ate	cemetery, crei	matory or c	other plac	- 1					
뜶	artme brtme brtent injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		DI.	insfie			,			Charlott Funeral		
Ba	Depermine of my in the process of th		Kyle Simons M01	1	w							nardtown		
4	70 2	П	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that cau	sed the deal	th. Do not en	ter tne mod	te ol dyin	g, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	A	The s) on o a	CA	Y2 ann (Y	· to	·				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	a consec	quence of):								
	Examine	.	Sequentially list conditions,	b. +2	idu	c to	1h	nh	و				_	
	led sit	Examlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consec	quence oi):								
_•	al-trar	xan	that initiated events resulting in death) Last	c Due to (or	as a consec	quence of):							-	
8760,	rate be executed hysicien and the burial-transit	lcal E		d										
	tificat ng phy as th	led												
Вох	death certifica e attending ph of for use as th	an/N	230. Was decedent pregnant	23c. If yes, outco 1 ☐Live birth]Ectopic p	regnancy				23d. Date		•
O.	0 0 9	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnan 9□ Unknow		death 5	Other (sp	pecify)				Mor	UI	Day Year
P.0	± 60 = ±		Part II. Other significant conditions co	ntobuting to deat	h but not res	sulting in the u	nderlying	alise dive	en in Part I		23e. Did to	phaceo use contri	bute to t	he cause of death?
Vital Records,	signed d be del	d by	•		,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Jang (310 a	aoriyg	audo giri	21. II. I Q. I I.				3 ☐ Prot	
COL	w requir	lete									24a. Was	an 24h W	Vere auto	psy lindings available
Be	0 = 0	Completed									autop perfo	rmed?	rior to co eath?	impletion of cause of
a	ılcian: Th certificete rector, paç	0	25. Was case referred to medical						26. Place	of Deatl	1 Yes		Yes	2 No
>	\$ W D	To B	examiner?	Hospital: 1 ☐ Inp	atient 2	ER/Outpatie	nt 3 🗆 DC	Othe	10	irsing Ho		lence 6 Othe	r (Specil	5)
	ding Ph h. After th funeral	ë	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month,	njury Day Year)	28b. Time o	f 2	28c. Injun Won	at c?		28d. Describe h	now injury occurre	bd	
sio	Attending r death. sctor: After by the funer	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				М		Yes 2□I					
=	l or Attendetter deatl Director: In by the	ertificatio	4 Homicide determined	28e. Place of building	Injury - At h , etc. <i>(Speci</i>	ome, farm, st fy)	reet, factor	y, office			28I. Location (S City or Tox	Street and Numbe vn, State)	r or Rur	al Route Number,
_	To the Hospitel or Atten within 24 hours efter deat To the Funerel Director: completely filled in by the	O	29a. Certifier 1 Certifying Phy	sician: To the he	ast of my kni	owledge deat	h occurred	at the tim	e date an	d place	and due to the	cause(s) and mar		tated
	24 h 24 h Fur letely	edical	(Check only 2 Medical Examione)	ner: On the basi and manner	s of examina	ation and/or in	vestigation	i, in my o	pinion, dea	th occur	ed at the time,	date and place, a	nd due t	o the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier				29	c. License	number			29d. Date signed	(Month.	Day, Year)
	-		Altr	CD			2	X56	200	(2/10/	136-	
			30. Name and address of person who c	ompleted cause	of death (Ite	m 23a) (Type,	Print)		Votch	4		1		
	18, 22		Archana Cry	A M	D 2	4535	Thr	ec 1	Votch	Re	(HOU	ywood	M	> 20636
	Sta Registi		31. Date liled (Month, Day, Year) FEB 1	3 2005	istra Sign	ature	ha	سنطا				J		

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrer Certificate of Death Reg. No. 0 0 5	627
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tin	me of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	Funeral Director		$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	itate or Foreign
	Maryland -f show	tor		ide City Limits
	with the	Direc	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
386	be filed within 72 hours after death with the Maryland tial Hygiene. id other then "natural", or items 23e or 28e-f show event, the Medical Erecting must be notified at	by Funeral Director	17311 Magruders Ferry Road 20613 U S A 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 20613 1. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 20613 1. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 20613 1. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 20613 1. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 20613 1. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 20613 1. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 20613 1. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 20613 20613	
21215-0036	12 should be filed within 72 ho h and Mental Hygiene. 7 is marked other then "natur Iraumatic event, the Madical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telephone Co	mnany
	ed tal	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	mperry
Maryland	should nd Men marke imatic	2	William Benjamin Richards Dora Canter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
ď۵	es 1 and of Healt fitem 2: r other 1		Mary Richards/Wife 20a. Method of Disposition 1 \(\frac{1}{3}\) Burial 2 \(\cap \) Cremation 3 \(\proper \) Removal from State 1 \(\frac{1}{3}\) Donation 5 \(\cap \) Other (Specify) 20b. Place of Disposition (Name of seminary of althoropace) 20c. Docation - City of Town, State Brookliield UMC Cemetery February 17, Upper Marlbo	oro, MD
Balti	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 20105 Three Notab Bond Charlette.	1. 1.11 MD
	Medical / Medica	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list rounities if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	al Between I and Death
.O. Box 6	The law requires that the death certificate ate has been signed by the attending physionage 2 should be detached for use as the last the last has a should be as a should be as the last has a should be a should be as the last has a should be a should be as the last has a should be a should be as the last has a should be a sho	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Year
rds, P	quires that in signed k uld be det	by	Part II. Other significant continuous continuous to the tatte of the t	
Il Records,		Completed	24a. Was an autopsy find prior to completion death? 1 \[\text{Yes} = 2\frac{1}{2} \text{No} \] 1 \[\text{Yes} = 2\frac{1}{2} \text{No} \]	n of cause of
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	
Division of	After After fune		A Contract of the Contract of	
Divi	in Site	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route City or Town, State)) Number,
	To the Hospitel within 24 hours a To the Funerel t completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated.	luse(s)
	To th within To th	¥	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye	ear)
			30. Name and address of rson wh completed cause of death (Item 23a) (Type, Print) Louis Kaufman, 12070 Old Line Center, Waldorf, MD 20602	
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registra & Signature	

		_	For State Registrar	State of Ma	iryland		rtment of H			Reg. N		05628
	Physici /Medic	an	1. Decedent's Name (First, Middle, Last) Roosevelt	Albert R	obin:	son			2. Date o Month Febru	art D	2 200	6 3:36 pm
	Examin Funeral	er	4a. Facility Name (If not institution, give s Union Hospital 5. Social Security Number 6. Sex 218-40-0796	of Cecil		nty ast birthday) Yrs.	4b. City, Town, o E. If Under 1 Year Months Days	lkton	4 Hrs. 8. Date o	f Birth	9. [eath ecil Birthplace (State or Foreign Country) ennsylvania
	Director wows 1-6		Usual Residence of Decedent 10a. State 10b. County Maryland Ceci:	1		, Town or Lo		n East	, mug •	23,		10d. Inside City Limits 1 ☐ Yes 2X No
9600	d within 72 hours after death with the Maryland Jiene. r then "natural", or items 23a or 28e-f show It e Medical Exeminer rust be mailled at	d by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2√2 No	Specify:	in? (Specify Yes o Puerto Rican, etc	ir No-		.A. merican Indian, rhite, etc. Black
and 21215-0036	be filed within ital Hygiene. id other then " svent, It e Mes	Be Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) Twelve Years 17. Father's Name (First, Middle, Last)	completed) College (1-4or 5		(Give life.	ents Usual Occup kind of work done DO NOT use retired Welde:	during most d) Ľ	's Name (First, Mi	Wi. Po	ley Mar rt Depo	nufactoring Co osit, Maryland
Baltimore, Maryland	nit. Pages 1 and 2 sh artment of Health and ortent: if item 27 Is m injury or other traum	To	19a. Informant's Name/Relationship (Ty Darryl R. Robinso 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensi	n (SON)	20b. P	19b. Mailin 21505 Place of Dispo emetery, cres erkley	Flight sition (Name of matory or other pla Cemetery Name and Addrese A. Pat	Lane,	r or Rural Route N. Tecumseh Date 02/08/06	, Okl 20c.	or Town, State ahoma Location - City	e, Zip Code) 74873 or Town, State n, Maryland
B	Physician /Medical Examiner	- P	23a. Part1. Enter the disease, or compleshock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate	cations that caused the cause on each line. Due to (or as but to (or as	PDIA a conseq	h. Do not enf	erryville er the mode of dyi	mg, such as	vland 2	1903-		Approximate Interval Between Onset and Death MWUTES DAYS
68760,	cate be executed physician and the burial-transit	dical Examiner	cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (o' as	a conseq			Dinbe	LTES	MELL	lTus	YEARS YEARS
O. Box	at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	Ideath 3[□Ectopic pregnanc □ Other (specify)	у			23d. Date of Month	Day Year
Records, P.	aw requires thats been signed	Completed by P	Part II. Other significant conditions co.	NASCU CK		Ulting in the C	nderlying cause gr	ven in Part I.	24a.	1 ☐ Yes Was an autopsy	2 No 3	e to the cause of death? Probably 4 Unknown a autopsy findings available to completion of cause of
of Vital	ng Physicien: ifer this certifice ineral director,	To Be	1 Yes 2 No 27. Mann of Death 1 Natural 5 Pending	Hospital: 1 Inpatie	iry	ER/Outpatie 28b. Time o Injury	of 28c. Inju	her: 4 🗆 Nu	of Death (Check of rsing Home 5 1 28d. Desc	only one) Residence		Yes 2 No
Division	r Attenter deat	al Certification;	2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Physicals	building, et	of my kno	fy) owledge, dear	reet, factory, office	ime, date an	28f. Locat City of	or Town, Sta	ate) (s) and manne	or Rural Route Number,
)	To the Hospitel or within 24 hours af To the Funerel D completely filled in	Medical	(Check only 2 ☐ Medical Example one) 29b. Signature and title of certifler MD	and manner st	ated.		29c. Licen	se number		29d. [Date signed (M	fonth, Day, Year)
ı	St Regist	ate rar	30. Name and address of person who c ANUD GAL-EI 31. Date filed (Month, Day, Year) FEB 0 7 2006	304 32. Registr	-306 rar's Signa	No	th S	reat	Suite	#3 E	Eucton	3,2006 Wayyord 2192

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Year 02 03 1:53 P 06 Kermit Leon Reynolds /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bowie
If Under 1 Year | If Under 24 Hrs. Prince Georges Bowie Medical Center 8. Date of Birth (Month, Day, 04 23 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**曇**M 2□ F Director 579-39-5171 74 Yrs ΝY Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. Count 10d. Inside City Limits 28a-f show Examiner must be notified at 1XIYes 2 □ No Director MD Prince Georges Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 23a 20774 9605 Lakepointe Court, #203 US Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No δ Specify: 3 X Widowed 4 □ Divorced "naturai", Black Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Case Manager Federal Government 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or othar traumatic event ONGs. 18. Mother's Name (First, Middle, Maiden Sumame) Be Julia B. Berkley ပ္ Francis Revnolds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fabayo N. Ogunsemowo/Daughter 9605 Lakepoint Court, #203, Largo, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Ceme 02-10-06 Suitland, MD 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Funeral Service Licensee 6500 Allentown Road, Camp Springs, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiac Arrhythmia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No peu P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes 2**/** No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No investigation death. 2 ☐ Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours e 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature at title of certifier 29c. License number D57028 02-07-06

CK (10)

State 31. Date filed (Month, Day, Year)

Registrar FFR 0 9 2006

Aditya Chopra, M.D.,

600 Ridgely Avenue, #231, Annapolis, MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar			and / Dep		t of H	ealth a	and M	ental Hyg		•	5630	
	Physici	an	1. Decedent's Name (First, Middle Elree	, Last) Roundtree							2. Date of Deat Month	Day	Year	3. Time of Death	
	/Medic	al			- 6 - 1		4. 63	-	1	(D	02	04	06 unty of Death	12:40 A M	
	Examir	ier	4a. Facility Name (If not institution						Location o				ince Ge	orges	
	Funeral		St. Thomas More 5. Social Security Number			rs. last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day,			place (State or Foreign	
	Director		242-26-9347	1 ∑X M 2□F	82	Yrs.	Months	Days	Hours	Min.	09 15			h Carolina	
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c	City, Town or Le	ocation							0d. Inside City Limits	
	Aaryli f aho	ъ	D.C.		1.00.	Washin								1 ty Yes 2 □ No	
	28a-	Director	10e. Street and Number	**		Washiin	10f. Zip	Code			10	Og. Citizer	of What Cour	ntry?	
	h with	<u>e</u>	2837 Monroe St	. N.E.			2	0018					USA		
	72 hours after death with the Maryland natural; or items 23a or 28a-f ahow disal Examirat rust be nutified at	Funeral	11. Marital Status	12. Was Dece Armed Fo	dent Ever in	U.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,		
36	or it	y Fu	1 Never Married 2 Marri	ed 1 🗆 Yes If Yes, Giv	2 No		1 ☐ Yes		Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, 5.5.,	Sp	ecify: Bla		
Ö	hours tural	Completed by	3 XWidowed 4 □ Divorced 15. Decedent	Year or Da	ates:		dent's Usua		ation				of Business/In		
15	iln 72 n "na	plet	(Specify only highes	t grade completed)	45.5.	(Give	kind of wor DO NOT us	k done d	during mos	t of workii	ng	IOD. KIIIG	Of Dusiness/iii	dustry	
212	d within 7 giene. er than "n	mo	Elementary/Secondary (0-12) 3rd.	College (1	-40r 5+)	Tru	ck Dr	iver				U.S.	Gover	nment	
pu	be filed y itel Hygie od other i	Be	17. Father's Name (First, Middle, I	.ast)					18. Mothe	er's Name	(First, Middle, N	Maiden Su	mame)		
yla		၉	George Roundt								Wilson				
Maryland 21215-0036	01 00 = =				-h+		-								
d)	l an Heal			DZIEL/Dau		. Place of Disp	osition (Nan	ne of							
nor	eges ant of it: If it		1 XBurial 2 ☐ Cremation		State	cemetery, cre	matory or o	ther plac		2-10-					
Baltimore,	permit. Peges 'Depertment of H Importent: If ite any injury or ot once.		19a. Informant's Name/Relationship (Type, Print) Cassaundrya Dozier/Daughter 2837 Monroe St. N.E. Washington, D.C. 20id 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) Ft. Lincoln 20c. Location - City or Town, State, Zip 20d. Place of Disposition (Name of cemetary, crematory or other place) Ft. Lincoln 22c. Name and Address of Facility MArshall's Funeral Ho 4217 9th. St. N.W. Washington, D.C. 2												
ñ	Depermine Depermine Important in procession of the procession of t		1 De Pman	chall		4	217 9	th.	St. I	.W.	Washing	ton,	D.C. 2	0011	
	Physician /Medical Examiner	ner	23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Applinted the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, line in the line i												
x 68760,	death certificate be executed e attending physicien end id for use as the burial-transit	/Medical Examiner	Causa Disease or injury that initiated events resulting in death) Last	c		equence of):						230	I. Date of delive	arv	
.O. Box		Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		inth 2 □ Fe ant at time o own		□Ectopic pr □ Other (<i>sp</i>					200	Month	Day Year	
S, P	S	ру Р	Part II. Other significant conditio			•	, 3	ause give	en in Part I					ne cause of death?	
ord	w requir been si should		End Stage Rer	al Diseas	se, De	pressio	n				1 □ Ye	s 2∐ñ	√o 3∐Prob	pably 4 Unknown	
Il Record	The ete h page	Completed	Cerebrovasçul	ar Accide	nt						24a. Was ar autops perform 1 Yes 2	y ned?	prior to co death?	psy findings available mpletion of cause of	
Vital	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	200		(Check only one				
of	ding Phys h. Alter this funeral dii	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investig	28a. Date of		ER/Outpatie		8c. Injury Work	4 20 140	4	me 5 Reside 28d. Describe ho			y)	
Division	el or Attending s efter death. I Diractor: After d in by the fune	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place	of Injury - Al	t home, farm, st cify)	reet, factory				28f. Location (Sti City or Town	reet and N , State)	lumber or Rura	al Route Number,	
	o the Hospitel or At ithin 24 hours efter of to the Funeral Dirac ompletely filled in by	edical (29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the examiner: On the ba and mann	best of my kasis of examiner stated.	nowledge, deat ination and/or in	h occurred evestigation,	at the tim in my of	ne, date an pinion, dea	d place, a	and due to the ca	use(s) an ate and pla	d manner as s ace, and due to	tated. o the cause(s)	
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	R		30. Name and address of person values V. Pab10-	Bustos N	1 D 1	160 Var		t. N	.Е. #	213	Washingt	ton,	D.C. 20	001y	
	Sta Registr		31. Date filed (Month, Day, Year)	32. R	egistrar's Sig	nature									

Registrar

			1- For State of Maryland / Dep Registrar Ce	eartment of Health and Mertificate of Death	lental Hygie	/11116	05632
	Physici /Medic		Decedent's Name (First, Middle, Last) Wilma Lee Robinson		2. Date of Death	Day Yes	3. Time of Death 9:30 a м
	Examir		4a. Facility Name (If not institution, give street and number) Homewood Nursing Home	4b. City, Town, or Location of Death Williamsport		4c. County of Death Washing	ton
	Funeral Director		5. Social Security Number 217-12-2261 6. Sex 1 M 2 XF 86 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Dec. 27,	9. Birthe Cour 1919 MI	place (State or Foreign htry)
	faryland set at	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L MD Washington William			1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the h	Funeral Director	10e. Street and Number 16505 Virginia Ave.	10f. Zip Code 2 1 7 9 5	10g.	Citizen of Whal Cour	
036	be filed within 72 hours after death with the Maryland tal Hygiene d other than "natural", or items 23e or 28e-f show event, i'm Medical Ena'd at Finat Le Incillis d at	ğ		Was Decedent of Hispanic Origin? (Spi If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
9500-61212	J within 72 ho jiene. r than "natur r wedicul	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Liming		dairy fa	
yland		To Be C	17. Father's Name (First, Middle, Last) Mayette Emerson Smith Sr.		e (First, Middle, Mai Willet 1		
, Mary	nd 2 should be should allth and 27 is m		19a. Informant's Name/Relationship (Type, Print) Keith Robinson grandson 1390	ing Address (Street and Number or Rura 4 Greencastle P	al Route Number, C.	ity or Town, State, Zip erstown, I	MD 21740
baltimore,	perrit. Pages 1 a Dep riment of Hes Important: if item any injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ematory or other place) I CD . I	٥,	agerstown	
ng Ca	Departit Depart Import any in		Maria Maria De	2. Name and Address of Facility Oonald Edwin Tho	_		•
l.	Enysician /Medical		resulting in death)	(ONEY)		g, MD 2	proximate Interval Between Onley and Death
	Examiner	<u></u>	Due to consequence of:	in		1	Gerras _
	executed n and al-transit	Examiner	Sou and the list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
09/90	ficate be executed physician and ts the burial-transit	edical	d				
C. Box	the death certificate be executed y the attending physician and iched for use as the burial-transit	Physician/M		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
ords, P	law requires that the de as been signed by the a 2 should be detached	by	Part Other significant conditions contributing to death but not resulting in the conditions are significant conditions. The conditions are significant conditions are significant conditions.	un mying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
	The la ate has page 2	e Completed	AMECTION (ONEVANY ANTES	NY DISCHE	24a. Was an autopsy performed 1 Yes 2 1 1	prior to cor death?	psy findings available mpletion of cause of 2 No
5	ding Physician: Th. h. After this certificate funeral director, pag	n: To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of	nt 3 DOA Other: 4 Nursing Hor		e 6 Other (Specification)	y)
NISION	To the Hospital or Attending Physician: within 24 hours after deals as the feature. To the Funeral Director: After this certific completely filled in by the funeral director.	ertification;	1 Vatural 5 □ Pending (Month, Day Year) Injury 2 (Accident investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined building etc. (Specify)	M 1 Yes 2 No		t and Number or Rura	l Route Number,
5	To the Hospital or Attendi Within 24 hours after death. To the Funeral Director: A completely filled in by the fo	O	29a. Certifier 1 N. Certifying Physician: To the hest of my knowledge deal	th occurred at the time, date and place,	City or Town, S	o(s) and mannor as sl	ated.
	To the He within 24 To the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and into organizers	nvestigation, in my opinion, death occurr	ed at the time, date	and place, and due to Date signed (Month,	the cause(s)
			30. Name and address of periof, who sompleted cause of death (Item 23a) (Type,	n 01706	ja j	2/9/Za	06
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	4 Kensycomia	AVE, 1	Macasta	eun,
2	Registr	ar	FEB 1 5 2006 Sugar D. A.	carde		Md d	1142

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe | | | Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear Physician Madeline Horsman Reid 2006 2202 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. Keggoral N le cheal Centr Wicomice 8. Date of Birth (Month, Day, Year)
March 23,1923

9. Birthplace (Sta Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days Months Hours 1 □ M 2 💢 F 82 218-16-5876 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Vienna Directo Maryland Dorchester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21869 USA 5139 Rhodesdale-Vienna Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Marned ŏ Specify: White 1 ☐ Yes 2 X No Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Deportment of Health and Mental important: if I tem 27 is marked c any injury or other traumatic ever 2008. Julian Clayton Horsman Nellie Spear 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Whitten/Daughter 25408 Deerfield Lane, Seaford, Delaware 19973 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) East New Market Cem. 2/11/2006 East New Market, MD 21. Signature of Funeral Service Licenses Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 Poil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only submits on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner URINARY TRACT INFECTION Securiting its conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Due to (or as a consequence of) Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ESOPHAGEAL ULLER RHEUMATOID ARTHRITIS 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? TIA, HYPERTENSION 24a. Was an page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 hpatient 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Hospitel or Attending Physician: The law requires thet the death certificate be executed Box 68760, P.0. Division of Vital Records, death. after death Director: , within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 104 MILFORD ST, #504B, SAUSBURY, MD 21504 NEMAL DOSHI 31. Date filed (Month, Day, Year) FEB 1 0

29b. Signature and title of certifier

HB~: MD

32. Registrar's Signature Social L

State

Registrar

D63433

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 0.00

			1 - For State Registrar	orace or mary		rtificate of			Reg. No.	Ub	05654
	Physicia /Medio		Decedent's Name (First, Middle, Las Dorothea J		emeier			2. Date of Dea Month	Day O	Year Ob	3. Time of Death 1913 M
	Examin		4a. Facility Name (If not institution, give	street and number)	Center	4b. City, Town, or	Location of Death		4c. Count	y of Death	(0
	Funeral Director		090-12-1339	ex 7. Age (In)	vrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 3/11/1	916	Cour	place (State or Foreign htty) inois
	ith the Maryland or 28a-1 show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Wicomi		City, Town or L					1	0d. Inside City Limits 1 X Yes 2 ☐ No
	th with th	Funeral Director	10e. Street and Number 1110 Healthway	Drive		10f. Zip Code 2180	04		10g. Citizen of USA		itry?
25	s 1 and 2 should be itled within 72 hours after death with the Maryland I Health and Menth Hygiens. Item 27 is marked other than "natural", or itema 23a or 28a-1 show ther traumatic avant. It a Medical Examinar must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	n U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Ra Bla Speci	ice - Americack, White,	
2-613-12	I within 72 ho liene. r than "natur It e Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of word d)	king	16b. Kind of E		dustry
2	2 should be filed withlic and Mental Hygiene. Is marked other than aumatic avant, the Mis	To Be C	17. Father's Name (First, Middle, Last) Harold W. Kupfer		SOC	TAL WOLK	18. Mother's Nam	ne (First, Middle,	Maiden Suma		
Mai	and 2 should ealth and Men n 27 is marke ier traumatic	-	19a. Informant's Name/Relationship (Diane R. maddex/			ing Address (Street Waters Ed	and Number or Ru	ral Route Numbe	er, City or Town		Code)
ני בו	permit. Pages 1 and 2 Deportment of Health a Importent: if Item 27 is any injury or other tra		20a. Method of Disposition 1 Burial 2 X Cremation 3 4 Donation 5 Other (Specify	meniovariioni State	b. Place of Disp cemetery, cre	osition (Name of matory or other place	De)	Date 1/06	20c. Location	- City or To	own, State
Dall	permit. Depertn Importe any injk		21. Signature of Funeral Service Light	rever CF	70 2	Name and Addre Holloway 501 Snow	ss of Facility Funeral Hill Rd.	Home Pro	ofessio	nal A	ssociation
	To the Hospitel or Attending Physician: The law requires that the death certificate be executed TO within 24 hours elater death. To the Funeral Director: Attent this certificate has been signed by the attending physician and TO the Funeral Director: Attent this certificate has been signed by the attending physician and TO the Completely filled in by the funeral director, page 2 should be detached for use as the burial-transit TO	Medical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	bications that caused the cone cause on each line. a. Ath Y W D Due to (or as a con Due to (or as a con C. Due to (or as a con d.	St /P 1/0 sequence of): My sequence of):					,	Approximate Interval Between Onset and Death
.C. DOY	the death certil y the attending iched for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	Fetal death 3	⊒Ectopic pregnancy ⊒ Other (specify) _	<i>'</i>		1	ate of delive	ery Day Year
, (SD)	equires thet sen signed brould be deta	ρ	Part II. Other significant conditions of AH 31 F M & V	/	resulting in the a	underlying cause giv	en in Part I.		obacco use cor res 2 No		he cause of death?
מו חמני	n: The law licete has b rr, page 2 sh	Completed	05 W(s)					1 ☐ Yes	osy med? 21046	Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
	nding Physicia ath. r: After this certi e funefal directo	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 Yo No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatie	of 28c. Injur Wor	ier: 4 🗆 Nursing H	ome 5 Resident Residence Page 1	dence 6 🗆 O		y)
	tel or Attars of selection of the select	Certification;	3 Suicide 6 Could not by determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, si	reet, factory, office		28f. Location (S City or Tox	Street and Num vn. State)	nber or Rura	al Route Number,
	the Hospi in 24 hour the Funer pletely fill	Medical	one) 2 Medical Exam	ysicien: To the best of my niner: On the basis of exan and manner stated.	knowledge, dea nination and/or in	nvestigation, in my o	pinion, death occu	, and due to the orred at the time,	cause(s) and n date and place	nanner as s , and due to	tated. o the cause(s)
	To Toon	2	29b. Signature and title of certified	toudila	MB	29c. Licens	3 4014		29d. Date sign	1	
	7mt		30. Name and address of person who MAMF3H M	001412 VA 10,	(Item 23a) (Type (Mi)	Print) Avd St	- 504	15 Sai	inslow	ryo	MS 2180
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 3 2	32. Registrar's S	ignature.	perty				,	

DHMH 17 Rev 1/2001

			1 – For State Registrar		I / Department of Health and Certificate of Death	Reg. No	1000 0000
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, La LSABELLA 4a. Facility Name (If not institution, giv	e street and number)	ROA-HOYOS 4b. City, Town, or Location of D	2. Date of Death Month Da D2 D4	c. County of Death
	Funeral Director		5. Social Security Number NONE Usuel Residence of Decedent		PITAL ROCK VILLE, N st birthday) If Under 1 Year If Under 24 If Yrs. Months Days Hours N 32	lin. (Month, Day, Year	MONTGOMERY 9. Birthplace (State or Foreign Country) MARILAND
	72 hours after death with the Maryland natural', or Items 23e or 28e-f show disal Evaninar musi be rodified at	Director	10a. State 10b. County MD MONTO	GOMERY GE	Town or Location ERMANTOWN, MA 10f. Zip Code	RYLAND 10g. C	10d. Inside City Limits 1 XYes 2 No itizen of What Country?
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural, or Items 23e or 28e-f show any injury or other traumatic event, the Medical Evantinal must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	ATER DRIVE 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	i. 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Pi	' (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
2121	led within 72 ho ygiene. her then "natur it, ine Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) NFANT	working	Kind of Business/Industry
Maryland	2 should be fii and Mental H Is marked ott raumatic even	To Be	17. Father's Name (First, Middle, Last	INDO ROA	19b. Mailing Address (Street and Number of	700	HOYOS ANG ARITA or Town, State, Zip Code)
3altimore, ∧	Pages 1 and ment of Health tent: If item 27 jury or other t		20a. Method of Disposition 1 Burial 2 Cremation 3 Communication 5 Other (Special Communication)	Removal from State	13609 DERWATER ace of Disposition (Name of metery, crematory or other place) ER (CLE 03	Date 20c. 1	tNTOWN, MD 20874 Location - City or Town, State ORGANTOWN, PA
Ball	permit Depart Import any in		21. Signatore of Funeral Service Lice 23a. Part 1. Enter the disease, or comshock, or heart failure. List only	plications that caused the death.	22. Name and Address of Facility SGAH, 9901 ME Do not enter the mode of dying, such as car	DICAL CENTE diac or respiratory arrest,	Approximate Interval Between
8760,	bath certificate be executed Example Control of the purial-transit and the purial-transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Respired of Due to (or as a consequence of the Control of the C	Destres Synd Prematurity	vme	Onset and Death 1 hour 32 hours
P.O. Box 68	The law requires that the death certificat the bas been signed by the attending phy agge 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal (4 Pregnant at time of deal)	death 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
	w requires that the de been signed by the a should be detached f		Part II. Other significant conditions	contributing to death but not resul	iting in the underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
tal Rec	siclen: The law is certificate has birector, page 2 st	Be Completed by	25. Was case referred to medical		26. Place of	24a. Was an autopsy performed? 1 Yes 2 N Death (Check only one)	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
. V.	Physiclen: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatient 2□E	Other	ng Home 5 ☐ Residence	6 □Other (Specify)
Division of Vital Records,	fter	Medical Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	(Month, Day Year)	28b. Time of Injury at Work? M 1 Yes 2 No	28d. Describe how inj 28f. Location (Street a City or Town, Sta	and Number or Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	edical Ce	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	nysician: To the best of my know miner: On the basis of examinati and manner stated.	vledge, death occurred at the time, date and p on and/or investigation, in my opinion, death o	lace, and due to the cause(occurred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	MO	29c. License number D 43 225	0,	Date signed (Month, Day, Year)
	Sta	ate	30. Name and address of person who MADHU NI 31. Date filed (Month, Day, Year)	completed cause of death (Item Shouly 22. Registrar's Signate	Grove Adventist Hospi	tal Rockvil	(e, MD 20850

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	4	For State Registrar	State of	f Marylar		artmer <i>rtificat</i>					giene Reg. No.	006	0	56	36
hysicia		1. Decedent's Name (First, Middle, La	ist)							2. Date of Dea Month	th Day	Yea		3. Time of	Death
/Medica	1	MaryAnn	Shaw							02	04	06		2:40) P
Examine	r	4a. Facility Name (If not institution, gi	ve street and nur	nber)		-		Location				County of De			
		9106 Friar Road 5. Social Security Number 6.		7. Age (In yrs.	In me brieffe days		. Was	hingt If Under		O Data of Bird		rince			
ineral rector		-	1 M 2 🔯 F	88 88	Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Day 02 1	6 17	1	Country)	Caro	_
Mo to		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d.	Inside C	ity Limi
fied	ğ	MD Prince	Georges	Ft	t. Wash	ingt	on							1X Yes	2 🗆 1
Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumetic event. Its Medical Examinat must be inclined at once.	Funeral Director	10e. Street and Number 9106 Friar Road					0744				10g. Citiz	zen of What	Country'	?	
ems 2	nera	11. Marital Status		dent Ever in U	J.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	.	14. Race - Ar			
al', or ite	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Fo 1 Tyes If Yes, Giv Year or D	2 X No e				Specify:		Hican, etc.)		Black, Wi Specify: B			
n "natur Vedical	Completed by	15. Decedent's E (Specify only highest gi		40151)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	ork done d	turina mos	t of worki	ng	16b. Kir	nd of Busines	ss/Indus	try	
ar the	E	12th.	College (1	-401 5+)	Admir	istr	ative	e Ass	ista	nt	Law	yers (ffi	ce	
rked otheric event	10 Be (17. Father's Name (First, Middle, Las Pinkny Lyde	t)							(First, Middle, cDuga1	Maiden	Sumame)			
27 Is mar treumet		19a. Informant's Name/Relationship Linda E. Hunter/		ghter-						d Route Numbe		,		ide)	
other	-	20a. Method of Disposition	ın-ıaw	20b. I	Place of Dispo	sition /Na	me of	1		shingto Date		cation - City		, State	
rtant: If i		1 ★Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Spec	ify)	State Rol Men	cemetery, cre [ling (norial	reen Park	other plac	θ)	02-10	0-06	Wes	t Ches	ter,	PA.	
any ir		21. Signature of Funeral Service Lice	insee	2	2:					shall's V. Wash					
sician edical miner		23a. Part is inter the disease, or cor shoot or hear failure. List only immediate Cause (Final disease or condition resulting in death)	aUr Due to	emia or as a consec	quence of):			g, such as	cardiac c	or respiratory ar	rest,		Int	oproximal terval Bet nset and	tween
# 1	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or mjury	D	d Stage or as a consec		. DIS	ease								
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be o	ò	Part II. Other significant conditions	contributing to de	eath but not res	sulting in the u	inderlying (cause give	en in Part I	-			se contribute ∑No 3□			
page 2 should	Completed									24a. Was autop perfo		24b. Were prior to death	o compl	findings letion of o	availal cause o
certificate rector, pag	9	25. Was case referred to medical	1							1 ☐ Yes		1 U Y	es 2[□ No	
this certific al director,	OP	examiner?	Hospital:	npatient 2	ER/Outpatie	nt 3 D	OA Othe			(Check only o					
or this aral dii	- -	27. Manner of Death		npatient 2 L of Injury th, Day Year)	28b. Time o		28c. Injury Work	4 🗀 140	_	me 5🔀 Resid			овспу)		
To the Funeral Director: After completely filled in by the funer	Certification:	1 X Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not determine	on be as size	of Injury - At h	Injury	М	1 🗆 '	<br Yes 2 □		28f. Location (S	Street and	d Number or	Rural R	oute Num	nber.
arel Dire	Cert	4 Homicide	buildi	ng, etc. (Speci	fy)					City or Tov	vn, State,				
he Fune	edicai	(Check only 2 Medical Exa	hysician: To the miner: On the ba and man	best of my knows asis of examination of examination of examinations.	owledge, deal ation and/or ir	h occurred ivestigation	at the time, in my of	ne, date ar pinion, dea	id place, i	and due to the ed at the time,	date and	and manner place, and d	as state	id. e cause(s	s)
Con	Σ	29b. Signature and title of certifier				\sum^{29}	c. License	onumber	24		29d. Dat	e signed (Mo	onth, Day	y, Year) 2000	6
1	i	30. Name and address of person who Dr. Andrew D.	completed caus	e of death (Ite	m 23a) (Type,	Print)	-/-	- , ,							

				1 - For State	State o		nd / Depa	artment		and Me	ental Hygie	ene n n 6	05	637
			0	Registrar 1. Decedent's Name (First, Midd	le, Last)			incate	Or Death?		Reg 2. Date of Death	j. No.	3. Tim	ne of Death
_		Physici /Medic		Jennie V	. Smith					Ē	enruary	Day JE	06 3	24 PM
		Examir		4a. Facility Name (If not institution		mber)		4b. City, To	wn, or Location	of Death		4c. County of E	eath	
	Eq. (*)		SF.	Doctor's					Lanha				ce Geor	
		Funeral Director		5. Social Security Number	6. Sex 1 □ M 2 🛣 F	7. Age (In yrs. 85	last birthday) Yrs.		Year If Under Days Hours	Min.	8. Date of Birth (Month, Day, Y		Birthplace (Sta Country)	
		N THE STATE OF THE		143-18-9102 Usual Residence of Decedent		63				ĮM	lay 28,	1920 N	ew Jers	sey
		anylan show		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						le City Limits
F		he Ma	ecto		ce George	s		_	anham					Yes 2 □ No
Smith		with t	Funeral Director	10e. Street and Number		#201		10f. Zip Ci	ode 207	06	100	. Citizen of Wha		
~		death me 23	era	11. Marital Status	enbelt Rd.	edent Ever in L	J.S. 13.	Was Deceder	t of Hispanic Or Cuban, Mexica		ofy Yes or No-		d State	
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	003	ural',	d by	3 Widowed 4 □ Divorced		Dates:		1 □ Yes 2 ∑	No Specify:			Specify:	Black	C
IR	15-	n 72 h	lete	(Specify only highe	nt's Education est grade completed)		(Give	dent's Usual (kind of work of DO NOT use	do <i>ne durina</i> mos	st of working	9 16	6b. Kind of Busin	ess/Industry	
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lictoria		be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Iteme 23a or 28a-f show event, it a Medical Exercities mant be redified at	BeC	17. Father's Name (First, Middle,	Last)						(First, Middle, Ma			
7	<u>ya</u>	should be filed with and Mental Hygiene. is marked other that eumatic event, train	To	Plummer H.		Sr.					Ella St	ates		
в	Maryland	d 2 should th and Men 27 is marke treumatic		19a. Informant's Name/Relation: Michele A. Whi		daughte					Route Number, (-		
ennie		Pages 1 and 2 ment of Health a tant: if Item 27 is lury or other tree		20a. Method of Disposition		20b.	Place of Dispo			Da		c. Location - City		е
12	Baltimore,	permit. Pages Department of Important: if I any Injury or once.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5	3 □Removal from Specify)				natory	2/8/2	006	Orang	e. NJ	
1 3	att	permit. Pag Department Important: f any Injury o		21. Signature of Foneral Service	Licensee	9-			Address of Facili		tewart I		-	
		20 E # 9		John T.	Speura						, N.E. V		C 20019)
4).	Physician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	r complications that of only one cause on a	caused the dea each line. TENSUL	Y			.0	respiratory arres		Oncot	imate Between and Death
		Examiner	}		Due to	(or as a consec	quence of):							
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		sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	(04.00.0.00000								
	760,	be exician burial	Icai E	, , , , , , , , , , , , , , , , , , , ,	Due to	(or as a consec	querice or).							
		fficate g physics the l			d									
	Вох 68	leath certifical attending phy I for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregn	ancy aldeath 3	Ectopic preg	nancy			23d. Date of		
	P.O. E	at the dea by the at stached fo	ysici	in the past 12 months? 1 ☐ Yes 2 ŒNo 9 ☐ Unknown		nant at time of o		Other (spec				Month	Day	Year
		that the hold by a detail	y Ph	Part II. Other significant conditi	ons contributing to d	leath but not res	sulting in the u	nderlying cau	se given in Part f	f.	23e. Did toba	cco use contribu	e to the cause	of death?
	rds	w requires been sign should be	ed b	CHRONIC P	ENAL	FAIL	URE				1 ☐ Yes	210 No 3	Probably 4	Unknown
	ဝ၁	e taw re has bed le 2 sho	piet	RENAL &	JEPSIS						24a. Was an autopsy	24b. Wer	e autopsy findi to completion	ngs available
	Ä	hysician: The ta his certificete ha I director, page 2	Com								performe	d? deat	h?	or cause or
	Vita	ician: Sertific ector,	Be	25. Was case referred to medica examiner?	Hospital, 1	,				e of Death	(Check only one)			
	o	Phys r this ral dir	-: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date		ER/Outpatien				e 5 Residen		Specify)	
	lon	nding Ph th. : After th e tuneral	atlor	1 Natural 5 Pendi		ith, Day Year)	Injury	м 200	Injury at Work?		5G. DOSC(100 110W	injury cocurred		
	Division of Vital Records,	the Hospitel or Attending Physician: The law requires that the death certificate be executed nin 24 hours efter death. the strifficete has been signed by the attending physician and the Funeral Director: After this certificete has been signed by the attending physician and npietely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification;	3 Suicide 6 Could 4 Homicide determ	nined 286. Place	e of Injury - At h ling, etc. (Speci	nome, farm, str ify)	eet, factory, o	ffice	28	3f. Location (Stre City or Town,	et and Number o State)	r Rural Route	Number,
		To the Hospitel or within 24 hours efter To the Funeral Direction completely filled in the funeral or the funeral filled in the fune	edical (29a. Certifier 1 Certifyii (Check ouly one)	ng Physician: To the Examiner: On the b and man	e best of my knopasis of examination	owledge, death ation and/or in	occurred at restigation, in	the time, date ar my opinion, dea	nd place, ar ath occurred	nd due to the cau d at the time, date	se(s) and manne e and place, and	r as stated. due to the cau	se(s)
_		To the within To the comple	Me	29b. Signature and utle of partifie	D. M.	10	11.	29c. L	icense number	10	290	d. Date signed (N	lonth, Day, Ye.	ar)
				Mullid	WY	107	SOM	フリ	168	7/		2-2	,-06	
C	L	10		30. Name and address of person WILL/AM DI	ROSSON	se of death (Ite	m 23a) (Type,	Print)	AUE 1) well	REPOLL	4011 1	ND 2	0784
- 1	- Marie	Sta Registr		31. Date filed (Month, Day, Year,		Registrar's Sign	ature	L)	10/10		1 7 000	1010/1	-	

State of Maryland / Department of Health and Mental Hygiene 05639 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Winifred Cynthia Spriggs January 31,2006 5:20P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 320 W. Bayfront Road Lothian Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year, Jul. 21, 1919 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months 088-12-7426 1 ☐ M 21 ☐ F 86 Yrs. **Director** Usual Residence of Decedent 10b. County Anne with the Maryland 10d. Inside City Limits 10a, State 10c. City, Town or Location r then "natural", or items 23a or 28a-f show Lothian 1 ☐ Yes 2 ☐XNo Director Maryland Arunde1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 320 W. Bayfront Road 20711 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ring most of working Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Supervisor(Statistic) 12 other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jonathan Walters Lillian Jessamy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dolores Dixon/Daughter Randallstown, MD 21133-2408 2 Hobart Ct. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Spriggs Cemetery 2/4/2006 Dunkirk, MD 22. Name and Address of Facility Sewell Funeral Home 21. Signature of Funeral Service Licensee Gladys 1451 Dares Beach Rd. Prince Fred., MD20678 sevell Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia. Physician 5 minures /Medical Due to (or as a consequence of): Examiner Atheroscienotic Cardio Vascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ mellitus 3 Probably 4 DUnknown 1 ☐ Yes 2 ☐ No Diahetes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Dementia. has autopsy performed? Director: After this certificate in by the funeral director, pag 1 Yes 2 No Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification; 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ţ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 ana. 50653 1-31-2006 ian GYAN -C. SURAWA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5851 Deale Churchton 20787 Road DeWe MP 31. Date filed (Month, Day, Year) 32. Registra Signature State FEB 2 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7, 7:00 AM February 2006 Wayne Elliott Stratton /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Rockville Casey House If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 23, 1 If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex X M 2 ☐ F **Funeral** Days Yrs. 52 1953 Pennsylvania Director 176-44-9489 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "netural", or items 23a or 28a-f ehow the Medical Examinat must be notified at 1 ☐ Yes 2 1 No Maryland Montgomery Gaithersburg Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23 N. Summit Drive Apt. 301 20877 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 is marked other than "netural", or ite 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White Specify: 1 ☐ Yes 2 【XNo 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16h. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Electrical Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rae C. Cohan Dana Daniel Stratton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn D. Stratton/brother 214 Fletcher Road North Kingstown, RI 02852 other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition February cemetery, crematory or other place) 0 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If ony injury or once. Chesapeake Crematory 9, 2006 Beltsville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finat **Physician** disease or condition resulting in death) a Metastatic Colon Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sicien and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. led by the attending physicien detached for use as the buria ician/Medicai as the l IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) Physi 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) hospice 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature of certifie February 8, 2006 D35635 62 30. Name and address of person pleted cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd. Rockville, MD 20855 Joseph Kaplan M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 0 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene, State Registrar Amend #23b per/fh 02-09-2006 entificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** STANLEY JAMES SUCHDOLSKI MEB 2006 6 13:59P [™] /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT 10 1953 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**Ø**M 2□F 148-48-7030 52 Director GÁ Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at MD MONTGOMERY POOLESVILLE 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after death with the Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "nortant of the traumation on the july or other traumation." 17308 CHISWELL ROAD 20837 USA 12. Was Decedent Ever in U.S. Amed Forces? 1 Ø Yes. 2 No. 1972 – I Yes, Give 1975 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1□Yes 2₽ No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT ANALYST 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be STANLEY SUCHDOLSKI, JR. JOAN ZANNIGAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY SUCHDOLSKI/SPOUSE 11 CEDAR RIDGE DR., TIFTON, GA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) FREDERICK CREMATORY 2/10/06 FREDERICK, MD 21. Signature of June al Service Litensee 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final SULLE **Physician** cerdias resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, flany lading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-transit or Attending Physician: The law requires that the deeth certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 🗆 Yes -2 🖟 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Sunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case reterred to medical examiner? 26. Place of Death | Check only one Hospital: Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28 e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Singoen MiD. 059929 02 - 64-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AARON SNYDER, MD 9901 MEDICAL CENTER DR., ROCKVILLE, MD 20850 31. Date filed (Month Day, Year) 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** February 15, 2006 Douglas 10:37 a.^Mm. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 22580 Old Rolling Road St. Mary's California 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Yrs. Director 232-42-8989 Nov.26, 1930 | Kentucky Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itema 23e or 28e-f ahow the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director St. Mary's California Maryland 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? 20619 22580 Old Rolling Road United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 K Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within al Hygiene. I other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Non-commissioned Officer U.S. Navy permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked othh any injury or other traumatic avant ans injury or other traumatic avant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sevier Scott Laura Pack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Scott / Wife 22580 Old Rolling Road, California, Maryland 20619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 2-17-2006 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.a. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Scizure Disorder **Physician** /Medical Due to (or as a consequence of): Examiner Status post Right Imag resectiva ue to (or as a consequence ot): for cancistoma, nemote Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed attending physician and for use as the burial-transit pidemia Penli Due to (of as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 28 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ď 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 2 PNo 1 Yes 2 No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 1 Yes 2 No 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending NA NA within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 Yes 2 No investigation 2 C Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 02/16/06 121893 Pett. Binner, m). 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROY H. BUNAVES, M.D. 22335 Exploration, Lexington Paris, MD20153 31. Date filed (Month, Day, Year) 32. Egistrar's Signature State FEB 1 7 2006

DHMH 17 Rev 1/2001

Registrar

			For State Registrar		State of	Maryla		oartmer e <i>rtifica</i> i			ind M	ental Hy	giene Reg. No.	06	056	43
7	5		Decedent's Name (First, Midd	le, Last)						_		2. Date of Dea		Year	3. Time o	of Death
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	/Medic Examin	154	4a. Facility Name (If not institution			nber)				Location of				ounty of De		
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	er de	Funeral	11. Marital Status		 Was Dece Armed Fo 1 ☐ Yes 	rces?	0.5.	If Yes, spe	ocity Cuba	an, Mexican	, Puerto I	cify Yes or No Rican, etc.)		Black, W		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Ma 3		If Yes, Giv Year or D	18		1 🗆 Yes	2 No	Specify:			S	Specify:	White	
21215-0036	n 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f ehow valoral Exercities must be notified at		15. Decede	nt's Educ	ation		16a. De	cedent's Usi	al Occup	ation			16b. Kind	d of Busines	ss/Industry	
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Maryland	should and Men is marke		19a. Informant's Name/Relation	ship (Typ	oe, Print)		19b. Ma	iling Addres	s (Street	and Numbe	r or Rura	l Route Numb	er, City or	Town, State	e, Zip Code)	
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alti	permit. Pages 1 Department of H Importent: if Ite any Injury or ot once.		21. Signature of Funeral Service	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rosewood Memorial 2-16-2006 Virginia 22. Name and Address of FacilityBrinsfield Funeral												
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	*		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complic	cations that o	aused the de	ath. Do not	enter the mo	de of dyin	ng, such as	cardiac o	r respiratory a	rrest,		Approxim Interval B	etween
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8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	cal		d	l											
9	nd pt	Med	IF FEMALE:							-	140.000	_				
Вох	eath certific attending p I for use as 1	an/I	23b. Was decedent pregnant in the past 12 months?	23	3c. If yes, out 1 ☐ Live b	tcome of preg pirth 2 □ Fe	etal death	3 □Ectopic		y			20	3d. Date of o	delivery Day	Year
	ne dea the at hed fo	Physician/M	1 Yes 2 No 9 Unknown		4□Pregr 9□ Unkn	ant at time o own	f death	5 🗌 Other (s	pecity) _						/	
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ū	ding Ph h. After th funeral	Certification:	27. Manner of Death 1 Natural 5 ☐ Pend		28a. Date (Mon	of Injury th, Day Year)	28b. Time Injur	У	28c. Injur Wor			28d. Describe	now injury	occurred		
Division	Attending or death.	catl	2 Accident inves 3 Suicide 6 Coul	tigation d not be	00 - 51	-/1-1 4	1	M		Yes 2 🗌		291 Leasting	Stroot on a	Number	Rural Route Nu	umbor
Σ	or At fler c jirec in by	T.		mined	28e. Place build	of Injury - Ating, etc. (Spe	t home, farm, <i>icify)</i>	street, facto	лу, опісе			City or To		ivaniber or	nurar noute ive	mber,
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			00 1000	- 6	maleted ==	no of docts "	tom (23a) /T	no Print'	110		, -		2	100	2006	
			30. Name and address of person						. L . D		1_116		MD 0	0610		
-10-	C+	ate	Jennifer Schr 31. Date filed (Month, Day, Yea			2341 Registrar's Sig		e Not	in Ko	oad, C	aııt	ornia,	MD 2	0019		
	Regist		FEB 14	200	العمر ١٥	em.	Nº 14	an est	•							
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State of Maryland / Department of Health and Mental Hygiene Reg. No. UUh Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3,2006 Month Physician February 5:45p M Eleanor Sullivan /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Manor Care-Potomac Potomac If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) March 20,1928 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1□M 2□F Yrs. Washington DC 577-36-8898 77 Director Usual Residence of Decedent with the Maryland 10c. City Town or Location 10d. Inside City Limits 10a State 10h Counts or 28a-f show rthen "naturel", or Iteme 23a or 28a-f ehov the Medical Examiner must be notified at DC Washington DC 1 Yes 2 □ No None Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20009 United States 3133 Connecticut Ave, N.W. deeth v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. Advertising Counsel Office Manager Ith and Mental Hygie 27 is marked other r traumatic event, it 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Martha Rogers Frank M.Sullivan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
eny Injury or other trat 10409 East Lake Dr., Oklahoma City, OK 73162 Gloria Counselman/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition N Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 2-9-06 Washington DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Son, INC 21. Signature of Funeral Service Licenses es 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER **Physician** RECTAL /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, I any, cooling to immodule cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of nding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No certificete 1 ☐ Yes 2 No : After this certifice e funeral director, r Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending To the Funeral Director: Aft To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier hund son and 0005 7124 217106 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13219 Executive Park Terr., Germantown, MD 20874 Dr. Truong Bao 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 08 2006 Registrar

			1 - For State Registrar	State of Maryl	and / Depa	artment o		and Me	ental Hygi	19 19	06	1564	5
	Dhusisi		Decedent's Name (First, Middle, Last)						2. Date of Death		Year	3. Time of [Death
	Physici /Medio		William Wallace Se	llers, Jr.]	February	y 5 ',	2006	10:55	Ам
	Examir		4a. Facility Name (If not institution, give st				wn, or Location	of Death			unty of Death		
			419 Russell Avenue				ersburg	-0411		1	tgomer		
	Funeral		5. Social Security Number 6. Sex 1246-07-0797	7. Age (In)	vrs. last birthday)		Pays Hours	Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or ntry)	Foreign
	Director		Usual Residence of Decedent		89				Jan. 24,	, 191	Nort	n Carol	lina
	yland		10a. State 10b. County		City, Town or Lo							10d. Inside City	y Limits
	Mar Be-f st	tor	Maryland Montgomer	У	Gaither	sburg						1 ⊠Yes	2 🗌 No
	or 28)ire	10e. Street and Number			10f. Zip Co	ode		10	g. Citizen	of What Cou	ntry?	
	23e	al	419 Russell Avenue	, #318		208	377		τ	Jnite	d State	es	
	r dea	Inei	11. Marital Status	2. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Deceden If Yes, specify	t of Hispanic O Cuban, Mexica	rigin? (Spec	cify Yes or No- lican, etc.)	14.	Race - Americ Black, White,		
36	or li	ΥF	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🛣 No If Yes, Give		1 ☐ Yes 2 ∑				Sp	ecify:		
21215-0036	72 hours after death with the Maryland 'natural', or Items 23e or 28e-1 show diest Examiner must be notified at	Completed by Funeral Director	15. Decedent's Educa	Year or Dates:	16a Doop	dent's Usual C	Decumpation		1 .	16h Kind	Whi of Business/In		
15	in 72 n "na fedic	olet	(Specify only highest grade	completed)	(Give	kind of work of DO NOT use r	done during mo: retired)	st of workin	9	IOD. KING	or Dusinessan	dustry	
212	iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		ctro Ch				Clect	ro Cher	mistry	
	illed I Hyg other	e C	17. Father's Name (First, Middle, Last)					er's Name	(First, Middle, N			HIBCLY	
a	ild be fenta rked ric ev	To Be	William Wallace Se	llers, Sr.			Clau	udia E	redrica	Orr	e11		
Maryland	should be should	_	19a. Informant's Name/Relationship (Type			-			Route Number,	-			
	and 2 valith a n 27 i		Gwendolyn G. Selle:					e, #31	.8, Gait	hers	burg, 1	MD 2087	7
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23e or 28e-f show among injury or other treumetic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	20	b. Place of Dispo cometery, crea Metropo	osition (Name matory or othe	of er place)	Februa	ary A		ion - City or To ndria,	own, State	
Ĕ	Pag ment ant:1		4 □ Donation 5 □ Other (Specify)	C	remator	ium, In	ic.	6, 200	06	Vir	ginia		
alt	sparti sparti sport ny inj		21. Signature of Funeral Service Consecutive		2:	2. Name and A	Address of Facil	lity DeVo	1 Funer	al H	ome,		
	207 29 9	MOUGOS TO East Deer Park Drive, Gaithersburg, MD 208										877	
\ sho∦k/(o/heart failure. List only one cause on each line.										Approximate Interval Betwo Onset and De	reen		
	Priysician		Immediate Cause (Final disease or condition	Multi	ple Myel	oma					5	Years	
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):								
	3	_	Sequentially list conditions, b.	Due to (or as a con	sequence off:								
	ted nsit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	240 (0) 43 4 2011	36406100 01).								
	sicien and burial-transit	xar	that initiated events c. resulting in death) Last	Due to (or as a con	sequence of):								
760,	ite be executed ysicien and ne burial-transit	call	d.										
89	death certificate b attending physic												
Вох	death certifica e attending ph id for use as th	In/M	23b. Was decedent pregnant	o. If yes, outcome of pre		∃Ectopic pregr	nanov.			23d.	. Date of delive	ery	
		sicla	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time 9☐Unknown		Other (special					Month	Day Ye	ear
P.0	that the death ned by the atter detached for u	by Physiclan/Med	9 Unknown						11				
	90		Part II. Other significant conditions conti	ibuting to death but not	resulting in the u	nderlying caus	se given in Part	1.				he cause of de	
ord	w requir been si should	ted							1 Ye	s 21XIN		ably 4 ∐Un	iknown
Records,	e law has b je 2 st	Completed							24a. Was ar autopsy	/	prior to co	psy findings av mpletion of cau	vailable use of
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Ö	o ir	Certification:	4 Homicide	building, etc. (Sp	ecify)	•			City or Town	, State)			
	spita hours unere y fille		29a. Certifier 1 Certifying Physic	cian: To the best of my	knowledge, deat	h occurred at t	the time, date a	nd place, ar	nd due to the ca	use(s) and	d manner as s	tated.	
	To the Hospital or Atten within 24 hours after deat to the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Examine one)	r: On the basis of exam and manner stated.	nination and/or in	vestigation, in	my opinion, de	ath occurre	o at the time, da	ite and pla	ice, and due to	the cause(s)	
	To the within comple	≥	29b. Signature and title of certifier	16	740	29c. L	icense number		29	d. Date si	gned (Month,	Day, Year)	
1	3		> Poseph M.	" aggerly	, INNS]	D32407		F	ebrua	ry 6,	2006	
	3)		30. Name and address of person who com Joseph M. Haggerty,	M.D. 9707	Item 23a) (Type, Medical	Center	r Dr.,	#300 ,	Rockvi	11e,	MD 208	50	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 8 2006	32 Registrar's Si	gnature	de							

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			For State Registrar	State o	f Marylan		artmen <i>rtificati</i>			and Mo		giene Reg. No.	006	05646	
			1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea			3. Time of Death	_
	Physicia		PHYLLIS		SOL	OMON					Month FEBRUAF	Day	Year 5 2006	- M	ł
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and nu	mber)		4b. City,	Town, or	Location of		I DDROIL	-	County of De		
	LAdiiiii	C!	5324 67th AVE				D	TWED	DALE			DI	TNCE (GEORGE'S	
	Eumanal			Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt	h I	943 9 B	irtholace (State or Foreign	n
	Funeral Director		579-56-2968	1 ☐ M 2 🖾 F	62	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Septemb	$\operatorname{er}^{Y_{\Theta ar}}$	6 Was	hington, DC	
			Usual Residence of Decedent				l								_
	ahow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	,
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	iled within 72 hours after death with the Maryland Hygiene, Hydiene, them 23e or 28e-f ahow ant, the Medical Examinar must be notified at	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.			spanic Ori	gin? (Spe	cify Yes or No-	.] 1	14. Race - Ап	nerican Indian,	_
	Ther of	ᆵ	1 ☐ Never Married 2 ☑ Married	Armed Fo			If Yes, spec	offy Cuba	n, Mexican	i, Puerto F	Rican, etc.)		Black, Wh		
2	irs a	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gir Year or D	ve		1 🗆 Yes	2KI No	Specify:				Specify: B1	ack	
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5	d be	9 Be	Timothy Silver	•					D	orot	hy Has	tv			
_	d Me	2	19a. Informant's Name/Relationship	(Type Print)		19h Mailii	na Address	(Street :			l Route Numbe		r Town State	Zin Code)	-
	12 s th an 7 is trau		William W. Solon		hand		•	•			ale, MD	-	20737	, 2,6 0000,	
ָ ט	Heali Heali em 2 ther		20a. Method of Disposition	ion/ nus		Place of Dispo			, 112		ate			or Town, State	_
2	or o		1 Burial 2 ☐ Cremation 3		State	mily C	matory or o	ther plac	e)					North Caroli	'n
•	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Deperment of Health and Mental Hygiens. Depertment of Health and Mental Hygiens. Insturally, or Itema 23a or 28a-f ahov important; Item 27 is marked other than "natural", or Itema 23a or 28a-f ahov any injury or other traumatic avant, the Medical Examinar must be notified at 000s.		4 □Donation 5 □ Other (Spec		rai										_
8	permit Deper Impor any in		21. Signature of Funeral Service Lie	encon.							B. Jenk				
_	405 ± 9		2100	<u> </u>							Landove		4D 207	1	_
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that of	caused the deat each line.	h. Do not ent	ter the mod	e of dying	g, such as	cardiac of	r respiratory ar	rrest,		Approximate Interval Between	
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3	ficat phy s th	edi	3												
<	death certifica ettending ph I for use as ti	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregna	ancy						2	23d. Date of d	lelivery	
<u>ב</u>	ette 1 for	cia	in the past 12 months? 1 ☐ Yes 2 ☒ No		oirth 2 ☐ Feta nant at time of d		⊒Ectopic pi ⊒ Other (sp						Month	Day Year	
,	y the	hysician/Me	9 ☐ Unknown	9□ Unkn	own										
	ires that the death cer signed by the ettendin d be detached for use	<u>a</u>	Part II. Other significant conditions	contributing to c	leath but not res	ulting in the u	inderlying o	ause give	en in Part I		23e. Did to	obacco u	se contribute	to the cause of death?	
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	for Attanding Physician: The las elfer death Director: After this certificete has Director: After this certificete has In by the funeral director, page 2	Certification;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date (Mor	of Injury hth, Day Year)	28b. Time o Injury		Bc. Injun Work			28d. Describe I	how injur	y occurred		
2	eath.	cat	2 ☐ Accident investigat				М	1 🗆	Yes 2 🗌						_
2	l or Attandi efter death. Director: A I in by the fu	ţ	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place	e of Injury - At he ling, etc. (Specil	ome, farm, st fy)	reet, factor	, office		2	28f. Location (3 City or Tox			Rural Route Number,	
ב	rat D led it														_
	Hospital 24 hours e Funeral (cai	29a. Certifier 1 ☐ Certifying I	Physician: To the	e best of my kno	owledge, deat	th occurred	at the tin	ne, date ar	nd place, a	and due to the	cause(s)	and manner	as stated. ue to the cause(s)	
	To the Hospital or Atlanding Physician: The law requires that the death certificate be executed within 24 hours eiter death. To the Funeral Director: Atler this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	one)	and mar	ner stated.										
	To T	Σ	29b. Signature and title of certifier				29	c. License	e number			29d. Dat	te signed (Mo	nth, Day, Year)	
	(1//	X		7)3	310	PQ		2	1610	6	
0	(10)		30. Name and address of person wh	o completed cau	se of death (Iter	n 23a) (Type,	Print)			-					
			GEORGE BONE M	i.D. 10) MERCAI	NTILE 1	LANE	SUIT	E 135	LAR	GO, MAR	YLAN	D 20/7	4	
	Sta	ite	31. Date filed (Month, Day, Year)		Registrar's Signa	aturo									
		7.7				155	-								

Robert Shelton 06-00932 crn

Funeral

Director

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death

within 72 hours after

Baltimore, Maryland 21215-0036

27 is marked other then "naturel", or iteme 23a or 28a-f ebov treumatic event, the Modical Examiner must be notified at

is marked other thereumatic

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Priysician

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this certificate

To the Funerel Director: After the completely filled in by the funeral

page 2

the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

Attending

Hospitel or 1 24 hours e

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within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 06, 2006 12:37 PM ROBERT VERNON SHELTON, SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3904 Regency Parkway, Apartment 204 Suitland Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, Year) Birthplace (State or Foreign Country) XX M 2□F 65 579 52 3159 OCT.21,1940 WASHINGTON, DC Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director YYes 2 No PRINCE GEORGES SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3904 REGENCY PARKWAY, #204 20746 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married XX Married 1 Yes XX No 1 ☐ Yes XXNo Specify: Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH PACKER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIE SHELTON ANGIE MALONE ဨ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3904 REGENCY PARKWAY, #204 SUITLAND, MD 20746 SHIRLEY SHELTON / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) RESURRECTION CEMETERY 02/14/2006 CLINTON, MD 21. Signature of Funeral Service License 2 MARSHALL Sof FUNERAL HOME OF MARYLAND, INC. laus 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Path. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic CardioVascular disease or condition resulting in death) Due to (or as a consequence of) Saluentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Cther (specify) ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 🕅 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2□No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) at Scene 1X Yes 2 □ No ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural 5 Pending investigation 1 ☐ Yes 2 | No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number. City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1_ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.

27 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner started. 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 2006

LING

RU

111 Penn Street, Baltimore, Maryland 21201 CI mis 32. Registrar's Signature

mis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O.C.M.E.

February 07, 2006

			For State	State	of Ma	ıryland	/ Depa	rtmen	t of H	ealth a Death	and M	ental Hy	giene Reg. No.	006	05648	
			Registrar 1. Decedent's Name (First, Middle	, Last)				- Tout	0 0, 2			2. Date of De	ath		3. Time of Death	_
П	Physicia		Margaret Sch	enker								Month 02/0	Day	Year 16	3:05 P M	
	/Medic Examin		4a. Facility Name (If not institution		umber)			4b. City,	Town, or	Location o	of Death	02/0		County of Deal	9.00	_
		•	Hebrew Home of	Greater	Was!	hingto	n	Rock	vill	.e			Mo	ntgome		
I	Funeral Director		5. Social Security Number 579-10-0298	6. Sex 1 □ M 2 F	7. Age	92	t birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Bir (Month, Da 09/16	th Y 1913	9. Bird Co Was	thplace (State or Foreign puntry) hington, DC	
	ס	ļ	Usual Residence of Decedent					1								_
	anylan show d at	_	10a. State 10b. County			10c. City, T		cation							10d. Inside City Limits 1 Yes 2 No	
	Ba-f	Director	MD Montgo	omery		Rocky	7111e	1					40. 0%	en of What Co		_
	a or 2	20	10e. Street and Number 6121 Montrose 1	2004				10f. Zip					USA	en or what Co	ountry :	
	ns 23	Funeral	11. Marital Status	12, Was De	cedent 8	ver in U.S.	13. \	Nas Dece	dent of Hi	ispanic Orig	gin? (Spe	cify Yes or No		4. Race - Ame		_
336	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show armatic event, I're M-cical Examinar must be notilied at	by Fun	1 ☐ Never Married 2 ☐ Marri	ed 1 Yes	W. Swie	lo		fYes,speo 1□ Yes		n, Mexican Specify:	i, Puerto i	ican, etc.)		Black, White, etc. Specify: White		
altimore, Maryland 21215-0036	72 hor	Completed	15. Decedent (Specify only highes	's Education	/)		16a. Dece	dent's Usua	al Occupa	ation	t of worki	na	16b. Kir	d of Business	/Industry	_
2	ithin 7 le.	nple	Elementary/Secondary (0-12)		(1-4or 5	+)				during most	or workin	9	Nati	onal I	nstitute	
2	led will lygien her th	Co	12	7			Stat	istic	ian	10 Matha	de Nome	(First, Middle		Health		
_	0 = 0 5	Be	17. Father's Name (First, Middle, I	Last)								(rirst, Middle	, maiden	ourname)		
<u> </u>	should id Me mark matic	ပ	Simon Sherman 19a. Informant's Name/Relationsl	nip (Type, Print)			19b. Mailir	ng Address		Ida F		I Route Numb	er, City or	Town, State,	Zip Code)	
<u>8</u>	nd 2 s ulth ar 27 is Estrau		Edward Schenker			- 17							-		MD 20906 er Spring,	
ē,	item		20a. Method of Disposition				e of Dispo					ate		cation - City or		
Ē	Page nent c		1	3 ∐Removal from Decify)	n State		-	-			02/0	6/2006	Fal	ls Chu	rch, VA	
a	permii. Pages 1 and 2 should bu Department of Health and Menta Important: If item 27 is marked any injury or obertraumatic en		21. Signature of Funeral Service	_icensee		/	22	Name ar Danz	ansk	y - GoI	dber	g Memo	rial	Chape1	s, Inc.	
m 	205 2 3		1 de				1	170 R	ockv	ille	Pike	Roc	kvill		20852	
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause or	each lin	10.									Approximate Interval Between Onset and Death	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)					CTIV	5	PilL.	MON	ARY	Dist	FASE		
	Examiner			Due	o (or as a	a consequer	nce or):									
		Jer	Sequentially list conditions,	b. Due t	o (or as	a consequer	10a ul).									
	cuted nd ransii	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c			onsequence of):									_
Ö,	cate be executed physician and the burial-transit	I Ex	resulting in death) Last	Due t	o (oras	a consequer										
8760,		dical		d												_
Вох		Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o		of pregnanc 2 Fetal de		Ectopic p	regnancy				2	3d. Date of de		ï
O. B	v requires that the death certif been signed by the attending should be detached for use at	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		gnant at	time of deat		Other (sp						Month	Day Year	1
0	that ft ed by detac	/ Ph	Part II. Other significant condition	ns contributing to	death be	ut not resulti	ng in the u	nderlying o	ause givi	en in Part I		23e. Did	tobacco u	se contribute t	o the cause of death?	
Records,	The law requires that the site has been signed by the bage 2 should be detache	ed by										10	Yes 🔀	No 3□P	robably 4 Unknown	
000		Completed										24a. Was		24b. Were a	utopsy findings available completion of cause of	
Ž		Com										perfe 1 🗆 Yes	rmed?	death? 1 ☐ Yes		
/ita	cian: ertific ector,	Be (25. Was case referred to medical examiner?	I da ià-l					0,4		of Death	(Check only	one)			
<u>}</u>	Physician: r this certifica ral director, I	T.	1 ☐ Yes 2 No 27. Manner of Death		Inpatie		Outpatier Bb. Time o			4 NL		me 5 Resi			ecify)	4
u O	ding l h. After funer	tlon	Natural 5 Pendin	9	onth, Day	Y Year)	Injury	M	28c. Injun Worl 1 □	k?" Yes 2□		200. Describe	now injury	Gooding		
Division of Vital	or Attending Ph ifter death. Director: After th in by the funeral	fica	3 Suicide 6 Could i		ce of Inju	ury - At homo	e, farm, sti	eet, factor							lural Route Number,	-
á	s after all Directory	Certification;	4 Homicide	bui	laing, etc	с. (Бреспу)						City or 10	wn, State,			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (g Physician: To t Examiner: On the and ma		examination										
	To th withir To th comp	M	29b. Signature and title of certifie		11			29	c. Licens	e number	CI		-	e signed (Mon		
	1		Lun	war	ux	My			V	1 80	07		トレは	RUAR	901,2006	>
)		30 Name and address of person	who completed ca	use of d	eath (Item 2	3a) (Type,	Print)	856	05	R	25211	1116	us	401,2006 20852	
	Sta	te	31. Date filed (Month, Day, Year)	32	Registra	C(2) ar's Signatur	1000	10 6	~~	1	/			7		
	Registr		FEB 0 9	2006	· Sylve	w B	67	ares								

MARGARUT

		1	For State Registra AMEND#17perFh2/1	State of M 3/06,BMW,N			rtment tificate			d Men		iene	006	05649
			Decedent's Name (First, Middle, Last)								Date of Deat	h Day	Year	3. Time of Death
	Physicia /Medic		RUTH GEYH SHARP				<u> </u>				BRUAR			5:50A M
	Examin		4a. Facility Name (If not institution, give st	reet and number,)		4b. City, To					4c. C	ounty of Death	
			BRIGHTON GARDENS			- 4 6 last 4 1	If Under 1		VILLE Under 24		Data of Birth			TGOMERY
	Funeral		5. Social Security Number 6. Sex	7. A	ge (In yrs. la	V				Min. (Date of Birth Month, Day, 21/19	Year)	Co	nplace (State or Foreign untry) ERTOWN, NY
	Director	-	116-10-2330 Usual Residence of Decedent		86)				10/	21/19	17	WAI	EKTOWN, NI
	yland		10a. State 10b. County		10c. City,	Town or Lo								10d. Inside City Limits
	e Mar	cto	MARYLAND MONTGOMER	RY 			ŀ	ROCKV						1X☐ Yes 2 ☐ No
	or 28	Dire	10e. Street and Number				10f. Zip 0				11	0g. Citize	en of What Co	
	ath w	ra	5550 TUCKERMAN LANE			110.1	No a Danada		0852	2 (Specify	Ves or No-	1,	U.S 4. Race - Ame	
	er de item	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	 Was Decedent Armed Forces 1 ☐ Yes 2 X 	?	13.	Was Decede f Yes, specif	y Cuban, N	Mexican, F	Puerto Rica	n, etc.)		Black, White	e, etc.
39	urs aff	by F	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:			Yes 2	No 5	Specify:			5	Specify: WH	ITE
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or llems 23e or 28e-f show the Medical Examiner must be notified at	Completed by	15. Decedent's Educi			16a. Deced	ient's Usual kind of work	Occupatio	n na most o	f working		16b. Kin	d of Business/	Industry
2	thin ?	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use	retired)				orn:		
2	lled w lygier her tl	S	17. Father's Name (First, Middle, Last)				HOM	EMAKE		Name (Fir	rst, Middle, M		HOME	
Maryland	d be f	Be c	GEYH CHARLES LOUIS GRYH								REINBE			
2	shoute mark mati	ř	19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailir	ng Address (Street and	l Number o	or Rural Ro	ute Number	City or	Town, State, 2	Zip Code)
Ma	alth ar 27 is 27 is		ELIZABETH ENGORON/I	AUGHTER	. /	9613	AUTUM	N OAK	S CT	, ROCI	KVILLE	, MA	ARYLAND	20850
Jre,	item sta		20a. Method of Disposition 1 □xBurial 2 □ Cremation 3 □ Re	mousi from State		ace of Dispo metery, crer				Date		20c. Loc	ation - City or	Town, State
<u>m</u>	Page ment o		'4 □Donation 5 □Other (Specify)	moval non State	NAT	IONAL	CREMA'	TORIU	M 02	2/10/	2006 F	'ALLS	CHURC	H, VIRGINIA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show wenty injury or dutal freumatic event, it is Medical Examinational barrotilled at once.		2 / Sign dur lof Faneral Sarvice License	9		DA	Name and NZANS	KY-GO	LDBEI	RG MEI	MORIAL	CH/	APELS,	INC.
_	- C - O O		23a. Part 7. Enter the disease, or complic	ations that cause	ed the death	Do not ent	70 RO	CKVIL	LE P	IKE,	ROCKVI	LLE,	MARÝI.	AND 20852 Approximate
	-		shock, or heart failure. List only one	cause on each	line.			-, -, 3,			,			Interval Between Onset and Death
	Pnysician / /Medical		disease or condition resulting in death)	DEHYDRA Due to (or a	TION is a consequ	ence of):								DAYS
	Examiner		Sequentially list conditions b.	,		,								
	p #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or a	is a consequ	ence of):								
	be executed ician and burial-transit	Examine	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or a	is a consequ	ence of):								
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Вох	eath certific attending pi for use as I	N/M	IF FEMALE: 23b. Was decedent pregnant	sc. If yes, outcom			∃Ect <i>o</i> pic pre	MUSUCA				2.	3d. Date of del	
	death	Physician/Me	in the past 12 months? 1 □ Yes 2 🏿 No	4☐Pregnant	at time of de		Other (spe						Month	Day Year
P.0	at the de I by the a stached	Phys	9 🗆 Unknown			tation the state of			in Don't		22a Did to	hacco us	co contribute la	the cause of death?
	res that signed b	by	Part II. Other significant conditions con			iting in the u	nderiying ca	use given	in Part I.			es X C		robably 4 Dunknown
orc	w require been si should I	eted	CANCER PANCREAS WI	IH METAS	THOIS						24a. Was a			itopsy findings available
Vital Records,	has has b	Completed						-			autops perfori	sy med?	prior to death?	completion of cause of
a		e Co	25. Was case referred to medical						6 Place o	of Death (C	1 Yes	2 No	1 ☐ Yes	2 No
5	Physicien: this certific ral director,	O B	avaminar?	ospital: 1 🗆 Inpa	tient 2□I	ER/Outpatie	nt 3 🗆 DO	Other					□Other (Spe	cify)
1 of		T:u	27. Manner of Death	28a. Date of In	niury	28b. Time o	f 28	3c. Injury at Work?			. Describe h			
ior	블 - 돌 글	atlo	1 ⚠ Natural 5 ☐ Pending investigation	(1.751117,75	,		М		s 2 No	_				
Division	l or Attendate after death	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of ! building,	Injury - At ho etc. (Specify	me, farm, st	reet, factory,	office		28f.	Location (S City or Town			ural Route Number,
Ω	pptel or ours after serel Dir filled in		29a. Certifier 1X Certifying Phys	ician: To the her	st of my know	uledne deal	h occurred s	at the time	date and	place and	due to the c	ause(s)	and manner as	s stated
	e Hospitel 24 hours a e Funerel letely filled	edical	(Check only 2 Medical Examin	er: On the basis and manner	of examinat	ion and/or in	vestigation,	in my opin	ion, death	occurred a	at the time, d	late and	place, and due	to the cause(s)
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in I	Me	29b. Signature and title of certifier	/.	10		29c.	License n		0.0	2		signed (Mont	
	8		> Kalua	u X	Z	_l,	,		D196	09		FEB.	RUARY 1	., 2006
	*		30. Name and address of person who co DR. RAMAN TULI, 10	npieted cause 810 DARN	death (Item NESTOW	N RD,	SUITE	202	, GER	MANTO	N, MD	208	78	
	* 1		31. Date filed (Month, Day, Year)		strar's Signa	huro #								
	Sta Regist	ate rar	FFR 0 9 2006	100	1	A CONTRACTOR	E.							

			_ FOI	epartment of Health and Certificate of Death		ene 2006 05650
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	Physicia /Medic		Constance Simmons		Februar	y 5, 2006 12:33 A ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	ath	4c. County of Death
			Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Takoma Park	s. 8. Date of Birth	Montgomery 9. Birthplace (State or Foreign
	Funeral Director		579-24-0253 1□M 20XF 89 Y	Months Days Hours Mi		1916 Washington, DC
1	and W		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town	or Location	<u> </u>	10d. Inside City Limits
	mary!	ō	Maryland Montgomery Silver	Spring		1X1Yes 2□No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
4	23a o	alD	1401 Blair Mill Road	20910		United States
3	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
	ars afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ▼ No Specify:		Specify: Black
	naturi	Completed	(Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of w	vorking	6b. Kind of Business/Industry
7	within lene. than	dmo	Flementary/Secondary (0-12) College (1-4or 5+)	ife. DO NOT use retired) Cactical Nurse		Medicine
2	other other went,	0	17. Father's Name (First, Middle, Last)		ame (First, Middle, M	
9	Menta Menta Menta arked arked arked	To B	Charles W. Coates	Amanda	a Ferguson	
<u> </u>	and ls mu	11	11111	Mailing Address (Street and Number or		
ຂ : ນົ .	l and lealth em 27 ther to			20 East West Highwa Disposition (Name of		Oc. Location - City or Town, State
	permit. Pages 1 and 2 should be filed within 72 hours affer death with the maryland Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural", or items 23a or 28a-f show any injug-eg other traumatic event, the Modical Examination in the horithed at once.		1 Burial 2 Kremation 3 Bemoval from State	crematory or other place)		eltsville, MD
	Departm Departm mports any Inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Mo		
	BOOK SEE		23a. Part1. Enter the disease, or complications that ceused the death. Do not	San		st. Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	~ Chmca		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a):		
·	Examiner	L	Sequentially list conditions, b.	A.		
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause Et al. Jeff in Sequence of Cause (Disease or injury):		
	icate be executed physician and s the burial-transit	Examin	that initiated events c. resulting in death) Last Due to (or as a consequence of):		
000	siciar siciar e buri	dlcal	d			
	tificat ng phy as th	Ψ.	15.55			
200	eath certificate be executed attending physician and for use as the burial-transit	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Date of delivery Month Day Year
5	The law requires that the death certif are has been signed by the attending page 2 should be detached for use a	Physician/M	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)		
ŗ	that the hold by detail		Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
cords,	w requires been sign should be	ed by			1 ☐ Yes	s 2 No 3 Probably Unknown
2	faw requ as been 2 should	Completed			24a. Was an autopsy	prior to completion of cause of
		Соп			perform 1 □ Yes 2	ed? death? √No 1 ☐ Yes 2√No
NICAL NICAL	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Other	eath (Check only one	
	Phys r this ral dir	. To	1 ☐ Yes 2 ☐ No Hospital:	atient 3 DOA 4 Nursing	Home 5 Resider 28d. Describe hove	nce 6 Other (Specify) w injury occurred
2015	th. After	tlon		me of 28c. Injury at work? M 1 Yes 2 No		
	Atter	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number,
5	ital or rs afte ra! Dir led in	Cert				·
	To the Hospital or Attending Physician: within 24 hours atter death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, 2 Medicel Exeminer: On the basis of examination and and manner stated.			
1	To th Within To th comp	Me	29b. Signature and title of ceptition	29c. License number	29	d. Date signed (Month, Day, Year)
	6		30. Name and address of person who completed cause of death (Item 23a) (1	ype, Print)	11	040 100
			Yeneyis WKGUSDIA,	m-D Wto	ch wister	n Hov. Hom
	Sta		31. Date filed (Month, Ba), Year) / 31. Registrar's Signature	parte		
	Registr	rar	LER A S TAME TO 10.			

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 11:06 PM Physician William Mayette Suder 12,2006 February /Medical 4b. City, Town, or Location of Death Hagerstown, Washington 4a. Facility Name (If not institution, give street and number)
Washington County Hospital Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign April 16,19 18 MD 6. Sex **Funeral** Months Days Hours 213-18-8944 1**⊠**M 2□F 87 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location
Williamsport 28a-f show the Medical Exeminar count be notified at Washington MD Y PSYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21795 U.S.A. Itams 23a or 222 Otho Holland Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. N Yes 2 □ No WWII MYes, Give Year or Dates: Specify: white filed within 72 hours after 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced natural Completed 16b. Kind of Business/Industry trucking Company 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if tlem 27 is marked other than "nt any injury or other traumatic event, the Mealth once. College (1-4or 5+) Elementary/Secondary (0-12) driver 0 6th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ora Lee Smith Henry Lewis Suder 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State. Zip Code) 12176 Cove Road Clear Spring, MD 21722 19a. Informant's Name/Relationship (Type, Print) Nathan Lucas nej nephew 20c. Location - City or Town, State Big Pool, MD 20b. Place of Disposition (Name of Feb. Date 6, 20a. Method of Disposition cometery, cromatory or other place) Feb. Parkhead Cemetery 2006 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc Ignature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approxisations and the death of Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute on chronice Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 by Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ficate has been sig r, page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2□ No 1 ☐ Yes 2 🐼 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification; To Date of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge: death accurred at the time, date and olane, and fine to the nause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ro the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 13/06 P006237-7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 368 MAGERITOWN MD 21740 MILL ST. 5H-4+1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Maryla	nd / Depa <i>Cer</i>	artment of F tificate of	lealth and M Death		iene () ()	6	05652
ı	Physicia		1. Decedent's Name (First, Middle, Last) Clementine K.	5	Stafford			2. Date of Dear Month Feb 16	, 2006	Year	3. Time of Death 3:30 am M
	/Medic Examin		4a. Facility Name (If not institution, give st 11123 Mexico Farm			4b. City, Town, o	Location of Death		4c. County Allega		
	Funeral Director		5. Social Security Number 6. Sex 212-38-7118		. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Apr 26	1		ace (State or Foreign
	Aaryland f ehow ad at	or	Usual Residence of Decedent 10a. State 10b. County Allegany		ity, Town or Lo Cumb	cation Derland				10	0d. Inside City Limits 1 Yes 2 No
	se or 28a-	Funeral Director	10e. Street and Number 11123 Mexico Farm	ns Road		10f. Zip Code	21502	1	0g. Citizen of V		
036	I within 72 hours efter death with the Maryland liene. Than "neturel", or iteme 23e or 28e-f ehow the Medical Examinar must be notified at	þ	11. Marital Status 1: 1 Never Married 2 Married 3 Wildowed 4 Divorced	2. Was Decedent Ever in I Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Spo an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	- America k, White, e	etc.
9200-5121	within 72 ene. than "ne he Medic	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) Coltege (1-4or 5+)	(Give	lent's Usual Docup kind of work done DO NOT use retired Operator	during most of work d)		16b. Kind of Bu		
Maryland 21	be filed atai Hyg ad othe event,	To Be Co	17. Father's Name (First, Middle, Last) George W. Duck	worth		,	18. Mother's Name		Maiden Sumam	e)	
	s 1 and 2 should f Heelth and Men frem 27 la marke other traumatic	1 87	19a. Informant's Name/Relationship (Type Betty Brown	daughter	19b. Mailin	g Address (Street 20 New Y	and Number or Rura ork Avenu	e Cumb	c. City or Town. erland	State, Zip MC	^{Code)} 21502
altimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	omoval from State Su	Place of Dispo cemetery, cren Inset Men	sition (Name of natory or other place norial Park	:e)	2/18/2006	20c. Location - Cumbe	•	
Balt	permit. Page Depertment of important: If any injury or once.		21. Signatur If Funeral Service License	hull	22		if Funeral Ho ginia Avenue		land, MD	21502	
	Physician		23a. Part / Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	ath. Do not ent	er the mode of dyin					Approximate Interval Between Onset and Death Veau
	/Medical Examiner			Due to (or as a conse							/
J	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse							
58/6 0,	ficate be executed physicien and is the burial-transit	edical E	d.								
C. Box	he death certif. the attending ched for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)	,		23d. Dat Moi	e of delive nth	ry Day Year
rds, P.	law requires thet the de es been signed by the a 2 should be detached	Ď	Part II. Other significant conditions cont Al Meccueur d		sulting in the ur	nderlying cause giv	en in Part I.	23e. Did tot			e cause of death?
Vital Hecords,	The la	Completed	<i>U</i>			<i>V</i> i		24a. Was a autops perform	ned?	Vere autor prior to con leath? Yes	osy findings available inpletion of cause of
_	Physician: The this certificete al director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 XNo Ho	ospitat: 1 🗀 Inpatient 2 🗀	☐ ER/Outpatien	t 3□ DOA Oth	26. Place of Death er: 4 ☐ Nursing Ho	me 5 Reside		er (Specify)
ion of	Attending Physician: r death. ector: After this certific by the funeral director.		27. Manner of D ath 1 ★ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 □No	28d. Describe ho	ow injury occurr	ed	
DIVISION	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At t building, etc. (Spec	:ify) 			28f. Location (St City or Town	n, State)		
	he Hospi n 24 hou a Funer	edical	29a. Certifying Physic (Check only one)	cian: To the best of my kn er: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the tir restigation, in my o	ne, date and place, pinion, death occurr	and due to the cared at the time, d	ause(s) and ma ate and place, a	nner as stand due to	ated. the cause(s)
	To t withi To tl	W	29b. Signature and title of certifier			29c. Licens	1/2341	0 7	9d. Date signed	(Month, I	Day, Year)
	6		30. Name and address of person who con	npleted cause of death (Ite	om 23a) (Type,	Print) Avo Su	ite 304;	aumho	rlam.	MA	21500
	Sta Registr		31. Date filed (Month, Day, Year) FFR 2. 4. 2006	32. Registrar's Sign	nature Coast	es con	-10 00 1)	MITTE	1 MUY	111/	5100

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Emmabelle Saylor February 20, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Cumberland Allegany Il Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Month, Day, Feb 12, Birthplace (State or Foreign
County) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🙀 F 1917 Director 220-38-0762 89 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylar Department of Heelth and Mental Hygiene.
Important: if item 27 is marked other than "natural", or iteme 23a or 28a-1 show any njury or other treumatic event, the Madical Examiner must be notified at once. 10b. County 10d. Inside City Limits Allegany Cumberland MD 1x Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21502 USA 29 Boone Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stella V. Russler Hess Largent Norman Hess 19b. Mailing Address (Street and Number or Rural Route Number, City or Toym, State, Zip Code) 31 Boone Street Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) daughter Anna Robertson 20b. Place of Disposition (Name of cometery, crematory or other pla Sunset Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 2/24/2006 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Namscarbeths Furtheral Home, PA 108 Virginia Avenue. Cumberland, MD 21502 23a. Part. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or condition resulting in death) Physician Due to (or as a consequence of) 24 hours Heart /Medical Examiner Devere tortic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ol) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physiclen Completed by Physician/Medical igned by the ettending phys be deteched for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes 1 ☐ Yes 2 1 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? the funeral director 26. Place of Death Check only one Hospital: Other: Certification: To 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Injury within 24 hours effer death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) ann MD February 20, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 William D. Lamm 900 Seton Drive Cumberland, Maryland 2,502 31. Date filed (Month, Day, Year) FEB 2 4 2006 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 14:04 PM Gilbert Garrard Simpson, Jr. rebruary 16 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Count Ellaton Cecil MIDA HOSPIFAL Cecil If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 📆 M 2 🗆 F Hours Min. Director 404-30-3994 JAN 25, 1928 Kentucky Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Nedical Example ratios for notified at 10d. Inside City Limits Director 1 V Yes 2 □ No Maryland Ceci1 North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 113 East Cecil Avenue 21901 United States Completed by Funeral 12 Was Decedent Ever in U.S. Amed Forces? WIII 1 MYes 2 □ No Korea 1 f7es, Give Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🎇 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Military/Commercial 15. Decedent's Education (Specify only highest grade completed) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Aviation Aviation Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gilbert Garrard Simpson Nellie Crook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If Item 27 I John M. Peterson/Grandson 15 West Reybold Drive, Middletown, Delaware 19709 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State West Chester, February Pages 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. Inc. 18, 2006 Pennsylvania Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Sign ture of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** myvila of Vater Adenocarcinoma 2 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list condlines if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): physicien Physician/Medical usa as t attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 obela oler 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 2 No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA

68760, P.0. of Vital s efter des... ral Director: After ... by the funeral di 0 To the Hospital or within 24 hours eft. To the Funeral Dis

Maryland 21215-0036

Baltimore,

Certification:

29a. Certifier

(Check only one)

Medical

State

Registrar

1541

1 🗌 Yes 27. Manger of Death 1 Natural 2 Accident 3 🗌 Suicide 4 Homicide

29b. Signature and title of certifier

5 Pending investigation 6 Could not be determined

ate of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MO D0055190 29d. Date signed (Month, Day, Year) February 17

une 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital 106 Bow Street Elkton MD 21921 MD

31. Date filed (Month, Day, Year) FEB 2 4 2006

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Uyroy 32. Registrar's Signature Goods

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legion amend item 23e per doc 2853 3-20-06 vt.
State of Maryland / Department of Health and Mental Hygiene 1 6 Certificate of Death Reg. No. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 06 09:30 M Kathryn Louise Soltis 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ceci1 315 Hermitage Drive E1kton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Min 1 ☐ M 2 🗓 F Hours Yrs 89 <u>221-24-5543</u> DEC 27, Pennsylvania 1916 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 315 Hermitage Drive 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No by Specify: Specify 3 X Widowed 4 □ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker In Her Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Musso Savina Bosio ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) K. Carole Soltis/Daughter 315 Hermitage Drive, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 ☐ Donation 5 ☐ Other (Specify) Newark, Delaware St. John's Cemetery ± 16.2006 Hicks Home for Funerals, P.A.

103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. D. not enter the mode of trying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Deat Peripheral Vascular Disease Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Cardiovascular Disease Due to (or as a consequence of):

Pnysician /Medical Examiner

transit

attending physician a for use as the burial-

the

is been signed by the 2 should be detached

has e 2

this After thi funeral

Director

within 24 hours after To the Funeral Dire

filled in by

page

Physician/Medical

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Completed

Be

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Certification:

Medical

The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

To the Hospital or Attending Physician:

death.

item 27 other tr

Department of H Importent: If its any injury or of once.

Physician

/Medical

Examiner

Funeral

Director

d 2 should be filed within 72 hours after death with the Maryland in and Mental Hygiene.
7 is marked other then "natural; or liems 23a or 28e-1 ehow traunatic event, the Medical Esaminar must be notitied at

Baltimore, Maryland 21215-0036

Examine

9 Unknown

25. Was case referred to medical

1 ☐ Yes 2 ☑ No

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE:

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?

2 Fetal death 4☐Pregnant at time of death 9 Unknown

1 ☐ Inpatient 2 ☐ ER/Outpatient

3 Ectopic pregnancy 5 Other (specify)

3□ DQA

28c.

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy performed?

111103 2 No 3 ☐ Probably 4 ☐ Unknown

24a. Was an 1 🗌 Yes 2 🔽

24b. Were autopsy findings available prior to completion of cause of death? 2 3 1 Yes

26. Place of Death (Check only one

	necify)
4 Nursing Home 5 Residence 6 Other (Sp	Jocny)

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined

28a. Date of Injury (Month, Day Year)

Hospital:

М 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury at Work? 1 ☐ Yes 2 ☐ No

Othe

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Dria

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number and)

29d. Date sidned (Month, Day, Year,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

JIMONS 31. Date filed (Month, Day, Year) FEB 2 4 2006 32. Registrar's Signature Cook.

State Registrar

DHMH 17 Rev 1/2001

Qe

Please 1 - For State Registrar	State of Maryl	and / Depa		Health and M	Mental Hygi	•	5 05656
Physician /Medical 1. Decedent's Name (First, Middle, La Elizabeth	Taylor T	Chomas	Ab Cib. Town	ar Location of Death	2. Date of Death Month 01-20-2	Day 2006	Year 3. Time of Death 5:05 p
Fulleral 570 06 7500	tist Hospital	L yrs. last birthday) 74 Yrs.		Park If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	gomery 9. Birthplace (State or Foreign Country)
Usual Residence of Decedent	10c.	. City, Town or Lo	ocalion Spring		05-09-1	931	Virginia 10d. Inside City Limit
Maryland Montgor 10e. Street and Number 9617 Clearview Pi			10f. Zip Code 209	01	10	0g. Citizen of V	
10a. State 10b. County Maryland Montgor 10e Street and Number 9617 Clearview 11. Marital Status 11. Marital Status 12. Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest gr Elementary/Secondary (0-12) Special Ed. 17. Father's Name (First, Middle, Lass unknown 19a. Informant's Name/Relationship	12. Was Decedent Ever i Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	Blac	e - American Indian, ik, White, elc. : Black
15. Decedent's E (Specify only highest group of the control of the	Education rade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of world)	king		siness/Industry Education
Special Ed. Special Ed.	17. Father's Name (First, Middle, Last) unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A 429 0				ne (First, Middle, M aylor	*	
19a. Informant's Name/Relationship Terrence Ford/ca 20a. Method of Disposition	se manager	429	O Street hington,	D.C.			State, Zip Code) City or Town, State
unknown 19a. Informant's Name/Relationship Terrence Ford/ca 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 (□ Donation 5 □ Other (Spectary Special Specia	Removal from State	cemetery, crer hesapeak	matory or other place Cremat 2. Name and Addre	ory 02-1	.0-06 H. Bacon	Beltsvi Funera	ille, Maryland I Home, Inc. , D.C. 20010
23a. Part1. Enter the disease, or conshock, or heart failure. List only medical stamphen and pending the pending of the pendin	b. Due to (or as a condition of the cond	sequence of):		Sisens			Interval Between Onset and Death
Side Sign of the past 12 months?	23c. If yes, outcome of pre 1 Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у		23d. Dai Mo	te of delivery nth Day Year
is a significant conditions	contributing to death but not	t resulting in the u	Inderlying cause gr	ven in Part I.		_	ribute to the cause of death
Comp						ned? c	Were autopsy findings avails prior to completion of cause death? I ☐ Yes 2 ☒ No
© 25. Was case referred to medical examiner? 1 □ Yes 2 ▼ No	Hospital: 1 1 Inpatient	2 ER/Outpatier	nt 3□ DOA Ot	hon	ome 5 Reside		er (Specify)
5 8	28a. Dale of Injury (Month, Day Yea	28b. Time o Injury	of 28c. Inju Wo M 1	ry at ork?]Yes 2 □ No	28d. Describe ho	ow injury occuri	
25. Was case referred to medical examiner? 1 Yes 2X No 27. Manner of Death 1 \(\text{Long of the conditions} \) 27. Manner of Death 27. Manner of Death 28. Accident investigating of the conditions of the	28e. Place of Injury - A building, etc. (Sp	oecify)	reet, ractory, orrice		City or Town	n, State)	o. o. riorar rioute (vumber,
© 2 € U 3 □ Suicide 6 □ Could not	hysicien: To he stall my	knowledge, deat	h occurred at the t	ime, date and place	, and due to the ca	ause(s) and ma	anner as stated.
29a. Certifier 1 🖾 Certifyi 🤰	hysicien: The My my minimer op he pasis of examand manner stated.	knowledge, deat	29c. Licen	me, date and place opinion, death occurse number	irred at the time, d	ate and place, 9d. Date signe	anner as stated. and due to the cause(s) d (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 0006

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1	For State Registrar
1	Decodentic

			1 - State Registrar		C	ertifica	te of De	ath	,	Reg. No.		
	Physic	an	Decedent's Name (First, Middle,	Last)					2. Date of De	ath	Year	3. Time of Death
	/Medi		MICHAEL KEITH TO						FEBRUA	RY 6, 2	006	10:20a. M
	Examir	ner	4a. Facility Name (If not institution, 9 8 STEPHEN LANE	give street and number)			, Town, or Loc UMPTON	ation of Death	1	4c. County QUEEN		ES
	Funeral Director		215-90-5134	5. Sex 7. Age ((In yrs. last birthda 32 Yrs	Months		Under 24 Hrs. ours Min.	8. Date of Bir (Month, Da FEB . 16	th ly, Year) 5, 1973	9. Birth Cou MD	place (State or Foreign ntry)
	and and		Usual Residence of Decedent 10a. State 10b. County	1.	10c. City, Town or	Location						I Od. Inside City Limits
	ith the Marylar or 28a-f ehow	5		ANNE'S	CRUMPTO							1 ☐ Yes 2X No
	28a-	Director	10e. Street and Number	HINE 9	CKUPIT I		p Code			10g. Citizen of	What Cou	
	N with		8 STEPHEN LANE			2	1628			USA		
	deet	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 1	3. Was Dece	dent of Hispan	nic Origin? (S	pecify Yes or No	- 14. Rac		can Indian,
2	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Heetin and Mental Hygiene. If Heetin and Mental Hygiene. Item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow other traumatic event, the Medical Examinat must be notilised at	þ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced			1 Tes, spi	ecify Cuban, M	pecify:	o riican, etc.)		ck, White, y: WH]	
ל י	72 hc natur	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. De	cedent's Usi	al Occupation	n a most of wor	kına	16b. Kind of B	usiness/Ir	dustry
4	Athin Den	Į de	Elementary/Secondary (0-12)	College (1-4or 5+))		ork done durin use retired)	g most or wor	nn g			
4	iled w tygier her ti		12 17. Father's Name (First, Middle, La	100	TREI	E REMO		Marked Ata	(Fine 14:4-#	TREE RI		<u>L</u>
	ntal hed of	Be							•	, Maiden Surnar	ne)	
	should be nd Mental marked c	2	THOMAS A. TOWERS 19a. Informant's Name/Relationship		10h M	ailing Addros	- 1		J. BUR	NS er, City or Town,	Cinta 7	
=	th and the and the treum		THOMAS A. TOWERS						GEVILLE		, State, 211 9933	Code)
	other tr		20a. Method of Disposition	J/TATHER	20b. Place of Dis	sposition (Na	me of	, DKID	Date	20c. Location		own, State
2	permit. Peges Depertment of h Importent: If Ite eny Injury or of		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		STEVENS	crematory`or		DV 02/1	0/2006	STEVENS	, 1777 7 1	e MD
	mit. F portm logur		21. Signature of Funeral Service Lice		STEVENS	22. Name a	nd Address of	Facility	8			
ă	Depermine ony ir		Dranco	N Kiao	ott	FELLO	WS HEI HAMROCK	FENBET ROAD	N & NEW	NAM FUNI	ERAL 21619	HOME, P.A.
	Physician /Medical Examiner	6 h	23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a Intra-o	Λ	otgun	₩ o (1	or respiratory a	mest,		Approximate Interval Between Onset and Death
,	ertificate be executed ding physicien and se as the burial-transit	l Examiner	Sequentially list conditions, If any leading L immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):									
	ate b hysic the b	lica		d								
		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	☐Fetal death	3 □Ectopic p 5 □ Other (s					ite of delive	ery Day Year
	quires thet n signed b uld be deta	b	Part II. Other significant conditions	s contributing to death but	not resulting in the	e underlying	cause given in	Part I.	23e. Did t	2		he cause of death?
200	8 C	Completed								OSV	Were auto prior to co de th? 1 X Yes	psy findings available mpletion of cause of
3	ien: rtifice	0	25. Was case referred to medical				26.	Place of Dea	th Check only o		Tes	2 No
•	nysic direc	To B	examiner? M☐ Yes 2 ☐ No	Hospital:	2 ER/Outpa	tient 3 D	100			dence 6XOth	ner (Speci	V SCENE
	fing Pr		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day)		У	28c. Injury at Work?			how injury occur		es (C
NO IN	or Attendations distributed the death Director: in by the	Certification;	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determine	t be	/ - At home, farm, (Specify)	•	1 ☐ Yes y, office	2000	28f. Location (City or To			al Route Number, 2h Lane
	To the Hospital or Atlanding Physicien: The within 24 hours atter death. To the Funeral Director: Atler this certificate h completely filled in by the funeral director, page	edicai Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of caminer: On the basis of e	xamination and/or	eath occurred investigation	at the time, d	ate and ulso n, death occur	and the title	ctuse(s) and in	ann ar as s	Interf
	ithin ; o the mple	Med	29b. Signature and title of certifier	and manner state	ru.		c. License nur			29d. Date signe		
1	F 3 F 8			em D			O.C.M		F	EBRUARY		
			30. Name and address of person wh	no completed cause of dea	th (Item 23a) (Typ	oe, Print)						

State Registrar

mito 31. Date filed (Month, Day, Year) 32. Registra's Signature

LING LI

111 PENN STREET BALTIMORE, MARYLAND 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene 116

		1	For State Registrar	State of Marylar		artment of H <i>rtificate of L</i>			eg. No.	00000
E1 15	Physicia		Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day Year	3. Time of Death
	/Medic	al	Everett 4a. Facility Name (If not institution, give str		ett	4b. City. Town, or	Location of Death	January	4c. County of Death	1:50 p ^M
*2 350	Examin	er	Calvert Memorial F				المحمامية عاد		Calver	t
	Funeral	-	5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec • 1	Year) 9. Birth	pplace (State or Foreign intry) 'Yland
, \$6°	Director		218-36-6851 Usual Residence of Decedent	88	rrs.			Dec. 1,	, 1917 Mar	ytand
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	8a-fs	Director	MD Calvert			Hunting	town	1	0g. Citizen of What Co	
	with the	Dire	10e. Street and Number			10f. Zip Code	639	,	USA	
	ms 23	nera	3610 Hunt Court 11. Marital Status	. Was Decedent Ever in Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba		ecify Yes or No-	14. Race - Amer Black, White	
36	illed within 72 hours after death with the Maryland Hyglene. ther then "natural", or Items 23a or 28a-f show that the Madical Examinational lacinoilled at	Completed by Funeral	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	,	1 ☐ Yes 2 ▼ No	Specify:	The start of the s	Specify:	nite
Maryland 21215-0036	2 hou	ted	15. Decedent's Educa (Specify only highest grade	tion	16a. Dece	dent's Usual Occup	ation during most of work	ina	16b. Kind of Business/I	
215	ithin 7	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)		agricult	1120
d 21	Hygier Hygier Ither th	CO	17. Father's Name (First, Middle, Last)			farmer	18. Mother's Name	e (First, Middle, I		uie
lan	lid be fental rked o	To Be	Samuel Bernard	Tippett		# n n n n n n n n n n n n n n n n n n n	Dora An	n Ethei	l Smith	
lary	2 shou and N Is mar		19a. Informant's Name/Relationship (Type	e, Print)		-			r, City or Town, State, Z	lip Code)
•	fealth m 27		Mildred E. Tippett		Place of Disp	osition (Name of			, MD 20639 20c. Location - City or	Town, State
mor	Pages ent of h nt: If ite ry or of	i	1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	i	cemetery cre	matory or other place	dens 01-28	8–2006	Dunkirk, M	D 20754
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or litems 23a or 28a-f show any injury or other traumatic event. The Madical Examiner must be notified at ance.		21. Signature of Funeral Service Licenses	Com		2. Name and Addre		- D λ	, Owings, N	∆D 20736
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the de						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CHRONIC	OBST	RUCTIUS	LUN	6 0158	EASE	Onset and Death UEARS
B	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):				_	
	acuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	B - 4 - 4						
68760,	icate be executed physicien and s the burial-transit	al Ex	Todaling in assum, east	Due to (or as a conse	equence or,					
		edical	d.							
Вох	eath certific attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of preg 1 Live birth 2 Fe	tal death 3	Ectopic pregnanc	у		23d. Date of de Month	ivery Day Year
	at the dea by the at tached to	ysici	1 Yes 2 No 9 Unknown	4☐ Pregnant at time of 9☐ Unknown	fdeath 5	Other (specify) _				
s, P.0	es that tigned by	by Ph	Part II. Other significant conditions cont	ributing to death but not r	esulting in the	underlying cause gr	ven in Part I.		obacco use contribute to	
ords	w require been sig should b	ted t						1 📿 🗸		robably 4 Unknown
Record	e las has	Completed							rmed? death?	utopsy findings available completion of cause of
Vital	ician: Th certificate ector, pag	0	25. Was case referred to medical				26. Place of Dea			2 □ No
of Vi	w =	To B	examiner? 1 ☐ Yes 2 ☑ No Ho		☐ ER/Outpati	ent 3LIDOA			dence 6 Other (Spe	ecify)
	n 000		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo	ryat rk?]Yes 2∐No	28d. Describe h	now injury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe				28f. Location (S City or Tox	Street and Number or R	ural Route Number,
۵	ital or irs afte ral Dir lled in									
	Hosp 24 hou Fune etely fil	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my k er: On the basis of exam and manner stated.	nowledge, de- ination and/or	atn occurred at the ti investigation, in my	ime, date and place opinion, death occu	red at the time,	date and place, and du	e to the cause(s)
_	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licen			29d. Date signed (Mon	
			PAtes OV	n		D 4	40370		1/26/06	
	5		30. Name and address of person and co	1 2 00	tem 23a) (Typ	e, Print)	DIQ	Foelon	1/26/06 ich MD	20678
*	St.	ate	31. Date filed (Month, Day, Year)	32. Registra/s Sig	gnature	deals an	M. 112.	IFICUEI	~ ~ · · · · · · · · · · · · · · · · · ·	
	Regist		TAN 2	3 2006 Man	isa b	Locale	0			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician February 11, 2:20 a.m. Trossbach 2006 Joseph Wayne /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St. Mary's Nursing Center Leonardtown Mary's 8. Date of Birth 11-23-1940 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1 **■** M 2 □ F 216-74-7546 65 Yrs. Maryland Director Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Madical Examinar nums be notified at 1 ■ Yes 2 □ No Director MD St. Mary's Leonardtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21585 Peabody Street 20650 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural, or Item eny injury or other treumatic event, the Medical Eventher's DRGS. 1 ■ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Never Worked Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Harvey Trossbach Mary Estelle Combs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Kaufman/Cousin 12942 Prices Distillery, Clarksburg, Maryland 20871 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State St. Michaels Cemetery 2-16-2006 Ridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Paperal Server Linsee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. 22955 Hollywood Road, Leonardtown, MD 20650 M00052 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pere neva a 20 tema Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Munany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence o) Examine signed by the attending physicien and dbe detached for use as the buriat-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MRSA cate has been sig page 2 should b archon' 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an certificate has 28 No 1 Yes 2 NO 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28c. Injury at Work? To the Hospitel or Attending Plewithin 24 hours after death.
To the Funerel Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 02/14/06 D60 888 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakhi Krishnan, 24035 Three Notch Road, Hollywood, Maryland 20636 31. Date filed (Month, Day, Year) 32. Registra Signature State FEB 1 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0.5555

			For State Registrar	State of Marylan		artment of F rtificate of			iene Ub	03000
	Physici /Medic		1 Decedent's Name (First Middle Last)	TURNBULL				2. Date of Death Month		ar 945 P M
	Examir		4a. Facility Name (If not institution, give st			4b. City, Town, o	r Location of Death		4c. County of I	
			Renaissance Gardens(Ride			Silver Sp			Prince (
	Funeral Director		133-10-2786	7. Age (In yrs. 80		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct.31,1	1916 Ne	Birthplace (State or Foreign Country) SW Jersey
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	e Maryl	ctor	Maryland Prince Ge	orge's Silv	ver Spi	ring			<u></u>	1 ☐ Yes 2X No
	ath with the Marylan 23e or 28e-f show ust be notified at	Funeral Director	10e. Street and Number 3142 Gracefield Roa	d, #MG508		10f. Zip Code 20904		10	Og. Citizen of Wha United S	
920	in 72 hours after death with the Maryland "naturet", or items 23e or 28e-1 show tedical Examinet must be notified at	Ď	11. Marital Status 1. Never Married 2 🕅 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cubi 1 ☐ Yes 2 🛣 No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		American Indian, White, etc. White
15-0	n 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	pation during most of world)	king	16b. Kind of Busin	ness/Industry
212	filed withi Hygiene. other than	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 1-4	Execu	tive Assi	.stant	E	Brewery (Company
Maryland 21215-0036	ld be ental ked c	To Be C	17. Father's Name (First, Middle, Last) Jeremiah Joseph	Spillane			18. Mother's Nam Helen	ne (First, Middle, M		ugrue
Mary	2 sh and Is m	-	19a. Informant's Name/Relationship (Type Hugh A. Turnbull -	*			and Number or Ru. .d Road,#1			
	permit. Pages 1 and 2 Department of Health Importent: If item 27 I any injuty or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	20b. F	lace of Dispo emetery, crea	osition (Name of matory or other place	ce)	Date 2	20c. Location - Cit	ty or Town, State
Baltimore,	permit. Pa Departmen Importent: any injury once.		'4 □ Donation 5 □ Other (Specify) 21. Signature of Fenaral (e) ice Litense							ington,Virginia PA
<u> </u>	89 = 9		1 Day 11111	Cin hay	44	400 Powde	er Mill Ro	oad Belts	sville, N	PA Maryland 20 7 05
	Pnysician	10 V	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on eagh line.		ter the mode of dyir	ng such as cardiac		ist,	Approximate Interval Between Onset and Death
	/Medical Examiner	Ш	resulting in death)	Due to (or as a conseq	uence of):	-				
	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Jusease or injury that initiated events c.	Due to (or as a conseq	uence of):					
68760,	tificate be executed ig physician and as the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):					
	± Dog	Medical	IF FEMALE:	c. If yes, outcome of pregna	1001					
.O. Box	The law requires that the death cerate has been signed by the attendir page 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 24 No 9 Unknown	1 Live birth 2 Feta 4 Pregnant at time of d	death 3	Dectopic pregnancy Other (specify)	y		23d. Date of Month	
٥	uires that signed by	þ	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	inderlying cause giv	ven in Part I.	23e. Did tob	_/	ute to the cause of death?
Records,	The law requate has been page 2 shoul	Completed						24a. Was ar autops perform 1 Yes 2	y prio	
a		e Co	25. Was case referred to medical				OS Place of Dec	th (Check only one		Yes 2□ No
Vital	Physicien: this certific ral director,	OB	examiner?	ospital:	ER/Outpatier	nt 3 DOA Oth		ome 5 Reside		(Specify)
on of	fter	-	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injur Wor	ry at		ow injury occurred	
Division	To the Hospitel or Attending within 24 hours after death. * To the Funeral Director: After completely filled in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Płace of Injury - At he building, etc. (Specif	ome, farm, str	reet, factory, office		28f. Location (Sti City or Town		or Rural Route Number,
	Hospite 24 hours Funeral etely filled	edicai C		icien: To the best of my kno er: On the basis of examina and manner stated.						
	Nithin Fo the	Me	29b. Signature and title of certifier	/		29c. Licens		29	9d. Date signed	Month, Day, Year)
	15		* The Me	Multo			3375	O	2/06/0	56
-	1-			M.D. 3160 Gr	acefie		Silver Sp	oring, Ma	ryland 2	20904
	. Sta Regist		31. Date filed (Month, Day, Year) FFR 0.8 200	32 Registrar's Signa	ture	arte				

	ald W. 7	Гау	Unpend item#23a,PII, 27, 28a-f, perME,G853.3/2)6 CC lelible Ink. 2/06 TT	Ensure Al	II Copies A	re Legiple.	05001
CT			1- For Registrar #1, perME, G854, 4/6/06 TI Cert	tificate of E	Death		. No.	05661
	Physici	an	1. Decedent's Name (First, Middle, Last) Donald Warren Taylor Donald W. Taylor			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir	cal		4b. City, Town, or I		February	17 200 4c. County of Dea	
3	Exami	lei	405 Muddy Branch Road #104	Gaithers			Montgom	
7179	Funeral Director		220-74-96/4 XM 237 46 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y NOV 4, 19	(ear) 9. Bi	nthplace (State or Foreign ountry) yland
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation				10d. Inside City Limits
	death with the Maryland ms 23s or 28s-f show rinust be invitited at	ctor	Maryland Montgomery Gaithersby	urg				1 X Yes 2 No
	with the	Funeral Director	10e. Street and Number	10f. Zip Code			. Citizen of What C	
	ns 23	erai	405 Muddy Branch Road, #104 11. Marital Status 12. Was Decedent Ever in U.S. 13. W	20878 /as Decedent of His	spanic Origin? (Sp		Jnited St	
ဖွ	or Iter	Fur	Armed Forces? If ' 1 □ Never Married 2 □ Married 1 □ Yes 2 (XNo	Yes, specify Cuban ☐ Yes 2 No	n, Mexican, Puerto	Rican, etc.)	Black, Whi	
89	ural',	d by	3 ☐ Widowed 4 K Divorced Year or Dates:		Specify:		Specify: W	hite
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylan Depertment of Heelih and Mentel Hygiene. Important: if Item 27 is marked other then "natural", or Items 23e or 28e-1 ehow empty injury or other traumatic event, the Madical Examiner must be inclined at ADGs.	Completed	(Specify only highest grade completed) (Give ki	ent's Usual Occupat sind of work done du O NOT use retired)	uring most of work	ing	86. Kind of Business	/Industry
	il Hygi other	4	17. Father's Name (First, Middle, Last)		18. Mother's Name		iden Suname) Be	
Maryland	Mente arked	TO B	Burliss Donald Taylor		Jeanette			LUICI
Mar	12 shows and 7 tems						City or Town, State,	
	1 end Heetti tem 2	2	20a. Method of Disposition 20b. Place of Disposi	ition (Name of	!		irg, Mary	land 20878
ē	Pages 1		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cometery, crema Parklawn 1	atory or other place. Mem. Park				Maryland
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8	\$9 E 2 9	9 7	M00956 933	3 GIST AV	811 وططور	ver Sprir	ig, Maryl	and 20910
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	r the mode of dying,	, such as cardiac o	or respiratory arres	t,	Approximate Interval Between Onset and Death
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P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the ettending physicies completely filled in by the funeral director, page 2 should be detached for use as the burn	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ E	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
	s thet	by Pr	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause giver	n in Part I.	23e. Did toba	cco use contribute t	to the cause of death?
ords	w require been sig should b		Cocaine use			1 ☐ Yes	2 0 No 3 □ P	robably 4 Dunknown
Rec	he faw r e hes be ige 2 sh	Completed				24a. Was an autopsy performe	24b. Were a prior to d. atl ?	utopsy findings available completion of cause of
ital	ysicien: The lar is certificate hes director, page 2	Be Co	25. Was case referred to medical		26 Place of Death	Check only one	No 112 e	s 2□ No
>	Physical this ce	ToE	examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Othor	·r-	me 5 🗆 Residend	ce 6x∏ Other (Spe	ecity) Scene
Division of Vital Records,	nding Phy th. r: After thi e funerel	Certification:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury Fn 2 Accident investigation 2/17/2006 Fnd 8:15 P	ad 28c. Injury Work?	at ? ′es 2 XNo	28d. Describe how UNK	injury occurred	
ivis	r Atte	tifica	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office		28f. Location (Stree City or Town,	et and Number of F State) 405 Min	Jural Route Number. IdyBranch Rd.
۵	pital o		Found at home			104 Gaither	sburg, MD	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 □ Certifying Physician: To the best of my knowledge, death of 2 □ Medical Examiner: On the basis of examination and/or investment and manner stated.	stigation, in my opi	e, date and place, inion, death occurr	and due to the caused at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the To the comp	M	29b. Signature and title of certifier	29c. License	number	29d	. Date signed (Mon	th, Day, Year)
			I sant great his		OCME	F	ebruary 1	.7, 2006
			30. Name and address of person who completed clause of death (Item 23a) (Type, Pr		n Stract	Do1+4-		1 - 1 01001
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	TIL Pen	m orreer	Daltimo	ore, Mary	land 21201
	Registr	ar	FEB 2 1 2006 A Company St. 1990					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1 **Physician** 25 2006 Wayne Lee Taylor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Washington County Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 17, 1953 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Months 1 X M 2 □ F Yrs Director Maryland 220-54-3697 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic avant, the Macifical Examinat must be multiled at 1 ☐ Yes 2 ☑ No Director Maryland Washington Williamsport 10f. Zip Code 10g. Citizen of Whal Country? 10e Street and Number 21795 USA 14241-R Falling Waters Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after XXYes 2 No 1973 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify 3 Widowed 4XX ivorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Trucking 9 Truck Driver permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othe any liury or other traumatic avent 90cs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wilma Regina Poffenberger Melvin Lee Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17610 Homewood Rd. Hagerstown, Maryland 21740 Jessie S. Taylor - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State Feb. 13, 2006 Williamsport, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park 21. Signature of Funeral Service Osbarne Acomeradiy Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Belween Onset and Death Hemotemesis / Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) **Physician** plood astantl /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con equipment) Examiner the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 cian/Medical IF FEMALE: 23c. If yes, oulcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnanl at time of death 5 Other (specify) the detached Physi 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? ρ 1 Xes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 220 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpalient 2 ER/OutpatienI 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred After Certification: Injury al Work? 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Direct 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29b. Sigpature and title of certifier 29d. Date signed (Month, Day, Year) 2 30. Name and add ss of person who concleted cause of death (Item 23a) (Type, Print) 31. Date filled (Month, Day, Year) EB 13 2006 32. Registrar's Signature State Registrar

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9	Francis		157 Konrad Mor 5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	Lot:		l If Under 24 H	rs. g	. Date of B	irth		Arun	del place (State	or Foreign
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	s 1 and 2 should be filed within 72 hours efter death with the Maryland f Health and Mentel Hygiene. Itam 27 is marked other than "natural", or itama 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status	12. Was De	cedent Ev	er in U.S.	. 13. \			ispanic Origin? an, Mexican, Pu	(Speci	fy Yes or N	0-	14. Ra	ce - Americ		
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ore	Pages 1 nent of He int: If Itan		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 Removal from	n State	20b. Pla	ce of Dispo netery, crer	sition (Nam natory or of	e of her plac	(e)	Dat	te	20c. l	Location	- City or To	own, State	
Ë	Pag tment tant:		4 Donation 5 Other (S	Specify)		Kal	as Cr		_		24–0				ter,		
Baltimore,	permit. Pages 1 and 2 Depertment of Health a Important: If Itam 27 is any Injury or other tra ance.		21. Signalure of Funeral Service	Licensee						ss of Facility							
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<u>α</u>	res that the de signed by the a l be detached t		Part II. Other significant conditi	ons contributing to	death but	not result	ing in the u	nderlying ca	use give	en in Part I.		23e. Did	tobacco	use cor	ntribute to t	he cause of	death?
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f V	Physician: this certific ral director,	ToB	examiner? 1 XYes 2 ☐ No	Hospital: 1] Inpatient	2 🗆 EI	R/Outpatien	it 3□ DO	A Oth					6) (50)	her (Specia	y Scen	ne
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_	pital ours cours naral filled		29a. Certifier 1 ☐ Certifyi	L'OUND ng Physician: To th	at ho		edge death	occurred :	at the tig	ne date and nis		othian,					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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	To the Mospitel or Attending Physicien: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director,	Me	29b. Signature and title of certifie	er				29c	License	e number			29d. D	ate sign	ed (Month,	Day, Year)	
			> Jasho	3 se	21	de	0		0	CME			Feb	ruar	v 18	2006	
			30. Name and address of person		use of dea	ith (Item 2	23a) (Type,	Print)				l			-		
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State of Maryland / Department of Health and Mental Hygiene 05664 1 - Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 9:00 РМ February 8, 2006 <u>Margaret Redman Unkle</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Marv's 44868 Rickle Hill Lane Callaway If Under 1 Year Months Days 8. Date of Birth July 23, 1928 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. Hours 1 ☐ M 2 👿 F 578-38-5448 77 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23s or 28s-1 show any injury or other traumatic event. The Madical Examiner must be notified at once. 1 Yes 2\No Director Maryland St. Mary's Callaway 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 44868 Rickle Hill Lane 20620 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 No Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: à 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Data Processor 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Eva Gertrude Evans John B. Redman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri Verbic-Roges / Daughter 22093 Phillip Drive, Leonardtown, Maryland 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1

Burial 2 □ Cremation 3 □ Removal from State
□ Donation 5 □ Other (Specify) Holy Face Cemetery 11, 2006 Great Mills, Maryland 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician chroniz failure renal /Medical Due to (or as a consequence of): Examiner multiple year mueloma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hypertensia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ◯ No 24a Was an certificate has autopsy performed? 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Pospital or Attending Post Pours after death.

Funeral Director: After the 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and fitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/9/ attending 2006 D0055682 ap and address of person who completed cause of death (Item 23a) (Type, Print) 23415 Three Notth Rd # 2052 California MD M. Wilkinson, MD homas 31. Date filed (Month, Day, Year) 32. Regimar's Signature State 2006 Dien & good Registrar

-05	774		1 - For State Registrar	State of Ma	aryland		artment o			-	giene Reg. No.	06	056	65
			Decedent's Name (First, Middle, Last)				-			2. Date of De	ath	V	3. Time of	Death
	Physici /Medio		Scott Matthew VAU	GHAN						FEBRUAR	$Y \stackrel{\text{Day}}{7}$	2006	0416	A M
)	Examir		4a. Facility Name (If not institution, give s	treet and number)			4b. City, To	n, or Location	on of Death	1	4c. Co	ounty of Deat		
			225 LILY COURT				HAGERS				WAS	HINGTO	N_	
	Funeral Director		5. Social Security Number 6. Sex 1X-	7. Ag	e (In yrs. la 33	ast birthday) Yrs.	Months D	ear If Und	der 24 Hrs. rs Min.	8. Date of Birt (Month, Da Feb. 2	y, Year)	Co	hplace (State o untry) XAS	r Foreign
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	3e or		225 Lily Court				101. Zip CC	21740			_	SA	unity:	
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920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "naturel', or iteme 23e or 28e-f ehow early injury or other traumatic event, the Medical Exacilisar must be troillied at ODGe.	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ⊠Yes 2 □ I If Yes, Give Year or Dates:	No		r Yes, specify I□Yes 22			o Rican, etc.)	Si	Black, White pec <i>ify:</i> wh		
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VIS	or Attend efter death Director: / in by the f	5	3 Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place of Inju	ury - At hor	me, farm, stre	eet, factory, o	fice		28f. Location (S	Street and I	lumber or Ru	ral Route Numi	ber,
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			1 Calilla	> Ale			0	CME			FEBRU.	ARY 8,	2006	
			30. Name and address of person who con	mpleted cause of d	eath (Item	23а) (Туре,	Print)							
54	1-5+1		ZABILICCALA 1	44	1	lll Pe	nn St.	, Balt	imore	, MD 2:	1201			
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	Registr	ar	FEB 1 0 20	UG Bee	w 1	4. D.	whis							

State of Maryland / Department of Health and Mental Hygiene 05666 Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 4, 2006 **Physician** Lillian Roberta Moreland Williams 11:26 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 505 Birch Drive Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months Days Hours Min 1 □ M 2 X F 94 Yrs 218-42-2962 July 19, 1911 Maryland **Director** Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Annapolis Maryland Anne Arundel Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 505 Birch Drive 21403 by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 235 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 🏋 No Specify: Specify: White 3XXVidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Henry Moreland Margaret Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Strucko/daughter 505 Birch Drive Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Cedar Bluff Cemetery 2/9/2006 Annapolis, Maryland 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemic Dilated Cardionyopethy 104 Physician disease or condition resulting in death) /Medical Examiner Coronary Artery Diseuse
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit law requires that the death certificate be executed Hypertens that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 1 ☐ Yes 2 XNo 5 Other (specify) this certificete has been signed by the a rai director, page 2 should be detached it 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes Z☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No r: After this certifice e funeral director, p or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 32No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 ⊠Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 ☐ Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannor as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW GORDON MD ZOO3 Medical Phay SE 100 ANNAPOLIS, Mi) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

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		1 Justin	M. Yinda	- M	0.0	C.M.E.			Febru	ary 1	14,	2006	
R(7)		30. Name and address of person w	no completed cause of death		Print) Penn Si	reet,	Balt:	imore,	Mary	land	212	201	
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	Examin	er	4a. Facility Name (If not institution, give 4 ATHERTON ROAD	street and number)			or Location of Deat		4c. County of Deat BALTIMORI	
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	land ow		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
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	an with the		10e. Street and Number 4 Atherton Roa	ı.d		10f. Zip Code	21093	1	Og. Citizen of What Co	_{untry?} d States
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Division of	Attending Prodesth. Sctor: After by the funera	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time (Year) 28b. Time Injury	Wo	ryat rk? Yes 2. ∰No	28d. Describe ho	w injury occurred Su	BJELT WAS ASSAULTED
Divi	ital or Attenors after death rai Director:	Certifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	rry - At home, farm, s . (Specify)	Home		28f. Location (St. City or Town	reet and Number or Ru n, State)	ral Rouje Number. RCTON TIM NIVM ND
	Hosp 4 hou Fune ely fil	edicai	29a. Certifier (Check only one) 1 Certifying Phy 2 Madical Exami	sician: To the best of mar: On the basis of and manner sta	examination and/or	ath occurred at the transversigation, in my	me, date and place opinion, death occu	a, and due to the caurred at the time, da	uuse(s) and manner as ate and place, and due	stated.
)	To tha within 2 To tha complet	W	29b. Signature and title of certifier	11		29c. Licens	se number OCME		Pd. Date signed (Mont) FEBRUARY 3,	
2	(2)		30. Name and address of person who co	ompleted cause of de	eath (ftem 23a) (Type	Print)	CTD FFT			
	Sta Registr		31. Date filed (Month, Day, Year)		r's Signature		STKEET,	DALITINKI	E, MARYLANI	, 41401
	negistr	ui –	FEB 0.8 2006	- Julian	-					

State of Maryland / Department of Health and Mental Hygiene 115 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 9, 2006 **Physician** 7:25 AM James Kenneth Wright /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Memorial Hospital Frederick Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex. **Funeral** Days Months Hours 215-26-8000 76 Oct. 5, 1929 Maryland **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Maryland Frederick Mount Airy Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23a or 803 North Warfield Drive 21771 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 5 Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) State Hospital 11 Licensed Practical Nurse . Fages 1 and 2 should be filed vitter of Health and Mental Hygie tant: If item 27 is marked other toury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Raymond Jugertha Wright Elva Naomi Spurrier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21771 19a. Informant's Name/Relationship (Type, Print) 803 North Warfield Drive, Mount Airy, Maryland Edna <u> May Wright - Wife</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Metropolitan Crematorium 2/11/06 Alexandria, Virginia 1 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Ameral Service Licensee Molesworth-Williams P.A., Funeral Home 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20872 Approximate Interval Between Onset and Death PHIMOUARY Immediate Cause (Final CHONNIC GEARS **Physician** disease or condition resulting in death) /Medical Examiner CIGARRETTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physiclan/Medical as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No Records, P.O. detached 9 Unknown signed by the 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 2 No Division of Vital il or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No M investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital of hin 24 hours at within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and February 9, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Culwell Drive, Mount Airy, Maryland 21771 Ronald E. Miller M.D. gistrar's Signatur 31. Date filed (Month, Day, Year) FEB 13 State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene () 05670 FOAMEND# 2 per phy. State
Registrar 2/15/06 AACO HEALTH DEPT. CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 6 3 P M Jimmy Rav Warren 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Odenton

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
Oct. 10, 1936 | 9. Birthplace (State or roreign. Country)

South Carolina 500 Bruce Ave. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 F Yrs 69 Director 248-54-1269 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo MD Odenton Anne Arundel 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? 21113 deeth v 500 Brüce Ave USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White etc. within 72 hours after 1 1 1 1 Nyes 2 □ No If Yes, Give Year or Dates: 1958–62 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: δ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within all Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Well Drilling Well Driller/Repairman 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill iment of Health and Mental H lant: If Item 27 is marked of Be Ibey Bogan James Warren 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 Bruce Avenue, Odenton, MD 21113 Joyce A. Warren (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MXBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. 2-9-2006 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet. Cem. Crownsville, MD 22. Name and Address of Facility 12 Ridgely Ave., Annapolis, MD 21. Signature of Funeral Service Licensee 21401 Hardesty Funeral Home P.A. 1 allac 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Conce /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 ician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? 2/2 No 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification; s ofter death.
I Director; Atter d in by the funers After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours e To the Funerel Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month Day, Year) 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Rafistrar's Signature State FEB 0 8 2006 Registrar

			State of Maryland / [irtment of He			ieme 0 0 6	05671
			Registrer 1. Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death
28	Physici	an	Helen Agnes Wisniewski				Feb.	7, 2006	4:07 a ^M
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
*1	Examin	er	1604 Marion Quimby Drive		Steve	ensville	ż	Queen	Anne's
_	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last bit	thday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birtl	place (State or Foreign
	Director		212-16-9556 1□M 2反F 83	Yrs.	Months Days	Hours Min.	(Month, Day, Mar. 1	, 1922	intry) MD
	ס		Usual Residence of Decedent						
	nylan		10a. State 10b. County 10c. City, Tow						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-1 s	cto	MD Queen Anne's Stev	zen:	sville				
	ih th	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What Co	untry?
	23a		1604 Marion Quimby Drive			666		USA	
	teme	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, White	
36	s afte	by F	1 ☐ Yes 2 M2 No If Yes, Give 3 1 ☑ Yes 2 M2 No If Yes, Give Year or Dates:	1 .	1□Yes 2ⅨNo	Specify:		Specify: Wh	ite
8	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f ehow ha Mudical Examiner charl De molified at	ed t	••	Decer	dent's Usual Occupa	ation		16b. Kind of Business/	ndustry
Ϋ́	in 72	Completed	(Specify only highest grade completed)	(Give	kind of work done d DO NOT use retired,	luring most of worki			
2	filed withi Hygiene. other than	mo	Elementary/Secondary (0-12) College (1-4or 5+)		Homemak	er		Home	
D	Hygin other	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, I	Maiden Sumame)	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-f show then traumatic event, the Medical Exptring Louisi be notified a	To B	Frank Wujek			Ann	a Zysk		
ary	should I ind Meni inarke umatic		19a. Informant's Name/Relationship (Type, Print)	. Mailir	ng Address (Street a	and Number or Rura	al Route Number	, City or Town, State, 2	(ip Code)
	1 and 2 Health a tem 27 is		Patricia Hornberger/Daughter	160)4 Marion		-	ensville,	
ore.	ges 1 ar it of Hea if item or other		cemate	f Dispo	sition (Name of matory or other place	Feb.	11,	20c. Location - City or	Town, State
Ĕ	Pages nent of I nnt: If its ury or o		1 ⊠Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Holy	Rosa	ary Cemet			Dundalk, N	ID ID
Baltimore,	permit. Pag Department Important: i any injury c		21. Signature of Funeral Service Licensee		Name and Address Sarranco & 95 Gov. F		.A. Sev	verna Park	Funeral Home MD 21146
			23a. Pan1. Enter the disease, or complications that caused the death. Do						Approximate Interval Between
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	cuted nd Iransi	Examiner	Cause (Disease or injury that initiated events c.		- · · · · · · -	<u> </u>			
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	that I	F.	Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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<u> </u>	sicle	Be c	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/O	utpation	nt 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho		ence 6 Other (Spe	cifu)
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	To the To the To the Complex c	Me	29b. Signature and title of certifier		29c. License	e number	4	29d. Date signed (Moni	h. Day, Year)
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			30. Name and address of person who completed cause of death (Item 23a)	(Туре,	Print)	130 1	ONEDON	of Road	SuitE 107
			PATRICIA A. KOWYER N	101	MPH	Char	NEPON	EMD 1	21606
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ral or	5. Social Security 218–14–	9 Number 7 6	6. Sex 7. A 1 M 2 □ F	Age (In yrs. 81	last birthday) Yrs.	If Under Months	1 Year Days	If Upder Hours	24 Hrs. Min.	8. Date of Bi	, 1924	9. Birti	hplace (State or Fore
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DHMH 17 Rev 1/2001

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MES	DANTE		RIGHI 1 - State Registrar	State of Ma	aryland / Depa	artment of h			giene 06	05674	
	Ag		Decedent's Name (First, Middle, Last)					2. Date of De.	ath	3. Time of Death	
	Physici		James Danie	el Wrig	ght			FEB.	6. 2006 Year	2327 P ^M	
	/Medio Examin	_	4a. Facility Name (If not institution, give s MARSHALL HALL PAI	treet and number)		4b. City, Town, o			4c. County of Dea	th ES	
	Funeral Director		5. Social Security Number 6. Sex 219 - 72 - 6566	7. Ag	6 (In yrs. last birthday) 33 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Mine	8. Date of Bird Cember	th 26,1972°	thplace (State or Foreign Washington	
	p ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	postion				10d. Inside City Limits	
	e Maryla la-f ahov	ctor	MD Charles	5	Indian					1 □ Yes 2 XNo	
	h with th	al Dire	10e. Street and Number 24 Highland P	lace		10f. Zip Code 20	640		10g. Citizen of What C	ountry?	
9	72 hours after death with the Maryland natural, or Itams 23a or 28a-f ahow disal Examinat must be notified at	by Funeral Director	1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 Yes 2X1 If Yes, Give	No	Was Decedent of I	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	- 14. Race - Am Black, Whi		
8	ural'.	d b	3 Widowed 4 Divorced	Year or Dates:							
Maryland 21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. ed other than "natural", or Itams 23a or 28a-f ahow avant, the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5	(Give		pation during most of work d) .ons Tec		Fiber O	Industry	
d 2	Hygid Hygid Sther		17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	-	
lan	ould be Mental arked o	To Be	Edward Nelson W	right,Jı	c.		Joan H	asting	S		
ary	s fand 2 should be f Health and Menta itam 27 la marked other fraumatic av		19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailir	•			er, City or Town, State,		
	s t and 2 f Health item 27 l		Karen Clement/D	aughter	THE RESERVE AND ADDRESS OF THE PARTY OF THE	THE RESERVE OF THE PARTY OF THE			a,Md 2064		
Baltimore,	m O L		20a. Method of Disposition 14 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Disponsion Commetery, creating Trinity		i	Date 2/11/0	20c. Location - City o 6 Waldorf	, Maryland	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	~ / / /	0945 A	REHART -	ress of Facility -ECHOLS FUNERAL HOEM, P.A. X 567, LA PLATA, MD 20646 Approximate Interval Retween				
	Physician /Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Intra-	the death. Do not entered the coval the death. Do not entered the coval the coval the death.	1	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death	
	Examiner	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (ur as	a consequence on:						
,092	ite be executed ysicien and ne burial-transit	cal Examiner	that initiated events resulting in death) Last		a consequence of):						
. Box 68	ath certifica ittending ph or use as th	Physiclan/Medi	in the past 12 months? 1 \(\subseteq \text{ Yes} 2 \subseteq \text{ No} \)	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnand Other (specify)	y		23d. Date of de Month	elivery D <i>a</i> y Year	
P.0	that the de led by the a detached f		9 ☐ Unknown Part II. Other significant conditions cor		out not resulting in the u	nderhing cause a	ven in Part I	23a Did t	obacco use contribute	to the cause of death?	
rds,	w requires the been signer should be co	ed by	Partition of the significant conditions con	inibuting to death b	action resulting in the d	Indenying cause gr		1 🗆	√	Probably 4 Unknown	
Il Records,	ysician: The law re iis certificate has be director, page 2 sho	Completed	-1/9-2								
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		10	26. Place of Dea				
o	Jing Pt J. After th funeral	tlon: To	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju	y Year) 28b. Time o	f 28c. Inju			dence 6 Nother (Sp how injury occurred - Shot his	nself	
Division	al or Attanding s after death. Il Director: After ad in by the fune	Certification:	2 Accident investigation 3 🛱 Suicide 6 Could not be 4 Homicide determined	building, et	jury - At home, farm, st. ic. (Specify)	reet, factory, office		28f. Location (City or To	Street and Number or F wn, State) Marsha Head mo	Rural Route Number,	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	ledical (29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best	of my knowledge, deat of examination and/or in	h occurred at the t	ime, date and place opinion, death occu	, and due to the	cause(s) and manner a date and place, and de	as stated. ue to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier				se number		FEB. 7, 2		

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L(NG LI in D 111 PENN S

31. Date filed (Month, Day, Year) 32. Registrar's Signature 111 PENN STREET, BALTIMORE, MARYLAND 21201

		1 - For State Registrar	State of M	aryland	-	artment of H		nd Mental Hy	giene	006	05675
		Decedent's Name (First, Middle,	Last)					2. Date of D		Year	3. Time of Death
Physic /Med		Walter		V	Vort	ıy		Febru	ary	6,2006	12:42PM
Exami		4a. Facility Name (If not institution,				4b. City, Town, o				County of Death	
		Fort Washi 5. Social Security Number		spital ge (In yrs. las		Fort V				ince G	
Funeral Director		579-46-1153	1 M 2 □ F	96	Yrs.	Months Days		Min. (Month, D Nov.	ay, Year)	09 Nor	place (State or Foreign ntry) th Carol.
ס		Usual Residence of Decedent						1.01.	,,,,		
arylar show	5	10a. State 10b. County MD Prince	Georges	10c. City, 7	rown or Lo Ldori						10d. Inside City Limits 1 X Yes 2 □ No
the M	Director	10e. Street and Number		Wal	Luoi	10f. Zip Code			10= Citi	zen of What Cou	
th with 23s or	ai Dir	3404 Accokee	k Rd.			Tot. Zip Code	2060)1		USA	iid y ?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other treumatic event, the Modical Examinar moust be muitibled at any once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	If Yes, Give	:?] No	'	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 X No	an, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)		14. Race - Ameri Black, White, Specify: Bla	etc.
2 hour	edb	15. Decedent's	Year or Dates:	OIVIC	16a. Deced	lent's Usual Occup	ation		16b. Kii	nd of Business/In	edustry
215 Din 72 M. na	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or		(Give	kind of work done OO NOT use retired	during most of	f working			,
212 2d with giene er the	S E	12	College (1-40)	34)		Check I					overnment
nd be file tal Hy d other	Be (17. Father's Name (First, Middle, L.						Name (First, Middle		Surname)	
Yla	2		orthy					ian Dutc			
Maryland 21215-0036 nd 2 should be filed within 72 hours all alth and Mental Hygiene. 27 is marked other than "natural" or retreumatic event, the Modical Exam		19a. Informant's Name/Relationshi Walter L. Wor			3410	Accoke	eek Ro	or Rural Route Numb 1, Waldo:	rf, City o	MD 2060	0 1
altimore, mit. Pages 1 ar partment of Hea portent: If item: y injury or other	-	20a. Method of Disposition	Bomoval from State	cem	netery cren	sition (Name of natory or other place	(e)	Date		cation - City or To	
Pages ment of h ent: If its ury or of		1 XBurial 2 ☐ Cremation 3 1 Other (Specific Specific S		* Asbu	iry (Chur	Inited N	Meth 2	1/11/06	Br	andywi	ne, MD
Balt permit. Depart import any inj		21. Signature of Funeral Service Li	pensee	191	22	. Name and Addre	ss of Facility		A-20 MD	605 Aqu	uasco Rd.
3300		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omp tion that cause	ed the death. line.	Do not ent	er the mode of dyin					Approximate Interval Between
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60, be executed sician and burial-transit		resulting in death) Last	Due to (or a	s a consequer	nce of):						
68760 cate be e physician s the buris	dicai	·	d								
Box 6 leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnanc	у					23d. Date of deliv	erv
death death dfor t	iciar	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pregnancy Other (specify)	·			Month	Day Year
P.O.	hys	9 Unknown	9□ Unknown								
dS, ires th signed	by	Part II. Other significant condition	s contributing to death	but not resulti	ng in the u	nderlying cause giv	en in Part I.			/	he cause of death? bably 4 Unknown
w requ	iete							24a. Wa	s an	24b. Were auto	opsy findings available
The lav	Completed							auto	opsy ormed? 2 No	prior to co death?	ompletion of cause of 2 No
	BeC	25. Was case referred to medical			•		26. Place of	Death (Check only		12.00	
	To	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 Inpat	tient 2 NEF	R/Outpatien	t 3 DOA Oth	er: 4 🗆 Nursi	ng Home 5 ☐ Res	idence (S □Other (Special	fy)
On O ding Ph h. After th funeral	ino ino	27. Manner of Death 1 ▼Natural 5 □ Pending		ury 28 ay Year)	Bb. Time of Injury	Wor	k?	28d. Describe	how injur	y occurred	
DIVISION Of I or Attending Phy after death. Director: After this d in by the funeral d	icat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	ot be	niuny - At home	o farm etr	M 1 [Yes 2 ☐ No		(Street an	d Number or Rus	al Route Number,
DIVISION Attences after death In Director:	Certification;	4 Homicide determin	building, e	etc. (Specify)	e, rami, su	set, ractory, office		City or To	wn, State)	ar riouto riambor,
Division To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medicai C	29a. Certifier 1 Certifying (Check only one)	Physician: To the bes xaminer: On the basis and manner s	of examination	edge, death n and/or inv	occurred at the tir	ne, date and p pinion, death	place, and due to the occurred at the time	cause(s) , date and	and manner as s place, and due t	stated. to the cause(s)
To th within To th	Me	29b. Signature and title of certifier	111			29c. Licens	e number		29d. Dat	e signed (Month,	Dey, Year)
		172	Ul	M	D	D4	6741		Feb	ruary	6,2006
0 = 1 :		30. Name and address of person w	1.1	death (Item 2			,			2	20744
mp 50+1	ate	Deepak Dac 31. Date filed (Month, Day, Year)	Ndeva /	trar's Signatur	0		ingsto	on Rd. F	ort	Washin	gton, MD
Regist			9 2006	Sur J	15 1	porte					

		1 - For State Registrar	State of M	faryland.		artment of I				jiene Neg. No.	06	05676
Physic		Decedent's Name (First, Middle, Last,							2. Date of Dea Month Februar	Day	Year 2006	3. Time of Death
/Med Exami		Mabel V. Wasson 4a. Facility Name (If not institution, give	street and number	r)		4b. City, Town,	or Location		reorua	-	inty of Death	
Exam		Regency Park Assis	sted Livi	.ng		Gambri	lls			Anne	Arun	del
Funeral		5. Social Security Number 6. Se		ige (In yrs. last		If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth (Month, Day	r, Year)		place (State or Foreign ntry)
Director		167-24-1054 Usual Residence of Decedent	A.	92	Yrs.				7-23-1	1913	Penr	nsylvania
yland yland		10a. State 10b. County		10c. City, T								10d. Inside City Limits
ith the Marytan or 28a-f show	ctor	Maryland Anne Arı	ındel		Davi	dsonvil]	.e					1 ☐ Yes 2 X No
ih the or 28	Director	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cou	intry?
ath w	rail	3324 Strawberry H		. =	1.0.1	2103		0 /0-	. 7. W N .		ISA	1-4
be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel", or Items 23a or 28a-f show event, it a Medical Evarinar must be multiped at	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Forces 1 ☐ Yes 2 2	?	13. \	Was Decedent of f Yes, specify Cul	an, Mexica	n, Puerto F	Rican, etc.)	14, 1	Race - Ameri Black, White	
ours at	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates			1□Yes 2XX No	Specify.	:		Spe	ecify:	White
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within no.	mpi	Elementary/Secondary (0-12)	College (1-4o	r 5+)		DO NOT use retire	ed)			Pos	taurar	a +
filled v Hygie ther t		8th 17. Father's Name (First, Middle, Last)			waı	tress	18. Moth	er's Name	(First, Middle,		taurar name)	IL
paritimities, Man yianto A.E.F.J.C.C.C.C.C.C.C.C.C.C.C.C.C.C.C.C.C.C	To Be	Edward	Hamel					Lill	Lian (u	unknow	m)	
2 should and Men Is marke	Ţ.,	19a. Informant's Name/Relationship (7)				ng Address (Stree						
and and the selfth mm 27 her tr		Eugene F. Wasson	Son			Strawber	ry Ru		avidsony		MD 2°	
Pages 1 nent of H ont: If ite		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ F		e cem	etery, crer	natory or other pla rematory	1	2-7-0			ater,	
permit. Page Department of Importent: If eny injury or once.	4 6	* 4 □ Donation 5 □ Other (Specify) 21. Signalury of union Service Licens		Rais		_	1					ral Home
Depar Depar Impol	4 5	VIII all				973 Solo			_			
		23a. Part1. Enter the disease, or composhock, or heart failure. List only o			Do not ent	er the mode of dy	ing, such as	s cardiac o	r respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	. We	MAST	B	L BI	210	T (MZE!	2		Onset and Death
/Medical Examiner		resulting in death)	Due to (or a	is a consequen	ice of):							
	ē.	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	ıs a consequen	nce of):						-	
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c									
e be executed sician and burial-transit		resulting in death) Last	Due to (or a	is a consequen	ice of):						13	
or ou, cate be executed bhysician and the burial-transit	Physician/Medical		d									
The law requires that the death certificate the has been signed by the attending physogo 2 should be detached for use as the	/Me	IF FEMALE:	23c. If yes, outcom	ne of pregnancy	y					23d	Date of deliv	/erv
death death	iciar	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	4□Pregnant	2 Fetal de at time of deat		Ectopic pregnant Other (specify)	cy				Month	Day Year
by the tachee	hys	9 Unknown	9□ Unknown									
w requires that the de been signed by the should be detached	by	Part II. Other significant conditions co	ntributing to death	but not resulting	ng in the u	nderlying cause g	iven in Part	1.	_			the cause of death?
requires een sign	ted								1 🗆 Y			,
e law has b	Completed								24a. Was autop	sy	4b. Were aut prior to co death?	opsy findings available ompletion of cause of
VICAL DE PROPERTOR SICIAN: The law certificate has rector, page 2	e Co	25. Was case referred to medical					OG Die	- of Doobh	1 Yes	No	1 Yes	2000
ysicia ysicia is certi directo	0 0	eyaminer?	Hospital: 1 □ Inpa	tient 2□ER	VOutpatier	it 3 DOA	hor		n (<i>Check only</i> o		Other (Spec	ASSISTED
19 Phy ter thi	D: T	27. Manner of Death 1	28a. Date of In	iury 28	Bb. Time of	28c. Inju	ury at	2	28d. Describe h		-	· CIVINO
eath. or: Af	catic	2 Accident investigation 3 Suicide 6 Could not be				M 1[Yes 2					
or Att	ertification;	4 Homicide determined	28e. Place of I building,	njury - At home etc. <i>(Specify)</i>	ə, farm, str	eet, factory, office	•	2	City or Tow		umber or Hui	ral Route Number,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	O	29a. Certifier Certifying Phy	sician: To the be	st of my knowle	edge, deatl	n occurred at the	time, date a	nd place, a	and due to the	cause(s) and	manner as	stated.
n 24 h	edicai	(Check only 2 Medical Exami	ner: On the basis and manner		n and/or in	vestigation, in my	opinion, de	ath occurre	ed at the time, o	date and pla	ce, and due	to the cause(s)
To t To t	Σ	29b. Signature and tille of certifier	7011	1		29c. Licer	ise number	Λ	:	29d. Date si	gned (Month	Day, Year)
		S VEAR DU	o XX	47		10	050	7		04	V0 1U	0
		30 Name and address of person who c	ompleted gause of	death (III) 2:	TYST.	E0031	Dorn	NAR	M DIS	D21	401	
S	tate trar	31. Date filed (Month, Day, Year) FEB 0 9 20	32 Regis	strar's Signatur	· A	anti	<u> </u>	- ,,				

			For State Registrar	State of Ma	ryland / Depa		lealth and M	lental Hygi	ene g. No. 006	05677
	J. Villa		1. Decedent's Name (First, Middle, La	est)				2. Date of Death		3. Time of Death
	Physic /Medi	cal	Marie 4a. Facility Name (If not institution, gi	Evelyn	Woodburn	4h Cihr Tourn o	Location of Death	February	Day Year 4 . 2006 4c. County of Deat	6:00 p.m.
12	Examir Funeral Director	ner	21724 Garfi 5. Social Security Number 6.3	eld Street	(In yrs. last birthday) 80 Yrs.	Grea	t Mills If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	St.Mar	
	and t		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation		nay 1, 1	J25 Hai	10d. Inside City Limits
	the Mary	ector	Maryland St.	Mary's		Ridge				1 ☐ Yes 2 ♣No
36	be filed within 72 hours after death with the Maryland nat Hyglene. ed other than "natural", or Iteme 23a or 28a-f ehow event, the Madical Examinat must be notified at	by Funeral Director	50425 Fresh Pon 11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	d Neck Road 12. Was Decedent Examed Forces? 1 Yes, Give Year or Dates:	ver in U.S. 13.	10f. Zip Code 206 Was Decedent of H If Yes, specify Cuba	80 ispanic Origin? (Spe in, Mexican, Puerto Specity:	U	g. Citizen of What Co Inited Star 14. Race - Ame Black, Whit Specify: Wh	tes vican Indian, e, etc.
21215-0036	within 72 houene. ene. than "natura	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation	(Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of worki	ng	6b. Kind of Business/	Industry
121	filed withi Hygiene. other than		12 17. Father's Name (First, Middle, Las.			omemaker	18. Mother's Name	(First Ministry 14	Own Hor	ne
Maryland	should be ind Mental I marked of matic eve	To Be	Thomas Spen	,	on				ile Bradbui	rn
Mary	2 should I and Men is marke		19a. Informant's Name/Relationship			ng Address (Street			City or Town, State, 2	
Baltimore, N	Pages 1 and 2 should nent of Health and Mer ant: If Item 27 is marke ary or other traumatic		Patrick D. Woodb 20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place of Dispo cemetery, crea	sition (Name of matory or other plac	е)	Date 2	Oc. Location - City or	
Baltir	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (Special Service Lice Edward N. Brinsii	nsøe	22		ss of Facility Bri	nsfield	Ridge, Man	ryland ome, P.A. O 20650-0279
8760,	Physician /Medical Examiner physicien and ph	Physician/Medical Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):				1	Approximate Interval Between Criset and Death Criset and Death Criset Amon Criset Crise
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit		nysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month
α.	luires that n signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the							
	ω · <u>·</u>	Completed						24a. Was an autopsy performe	prior to d	itopsy findings available completion of cause of
Vital	Physiclan: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	t 2 ER/Outpatier	other SCIDOA Other	26. Place of Death	(Check only one) me 5 ☐ Residen		
o	ding h. After fune	ertification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day	28b. Time o	f 28c. Injury Work	at 2	28d. Describe how		Home
Division	9 th C ⊆	Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)						iral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Pl (Check only one) 1 Medical Exa	nysician: To the best of miner: On the basis of e and manner state	examination and/or in	h occurred at the tim vestigation, in my op	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
\	To T To T	Σ	29b. Signature and title of certifier	1-0	- ~~	29c. License		290	d. Date signed (Monti	h. Day, Year)
			30. Name and address of person who	· / / /	ath (Item 23a) (Type.		1728		February	7, 2006
			Patrick Cros	s, M.D., 25	5500 Point		Road, Lec	nardtown	ı, Marylan	d 20650
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Sanature	& Speed	٧			

		•	For State Registrar		Marylan		artment of tificate o				eg. Nő.	06	056	
ī	Physici	an	1. Decedent's Name (First, Middle, La Mary Frances Wr:							2. Date of Dea Month	Day	2006	3. Time of 5:20	
)	/Medic Examin		4a. Facility Name (If not institution, given 22937 Thawley Ros	e street and numi	per)		4b. City, Town		of Death	tebruar,	4c. Co	unty of Death Caroli	1	
	Funeral Director		220-01-9009	Sex 7 I□M 2∑∏ F	. Age (In yrs. 9	last birthday) 4 Yrs.	If Under 1 Ye Months Day		Min.	8. Date of Birth (Month, Day June 2,	, Year)	Cou	olace (State o ntry) Anne	-
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Denton									10d. Inside Ci	ity Limits 2 🗆 No	
	or 28a-	lrect	10e. Street and Number				10f. Zip Cod	6		1	l0g. Citizer	of What Cou	ntry?	
	238 c	ralD	22937 Thawley Ro				21629				USA			
36	should be filed within 72 hours after death with the Maryland and Mental Hyglene. In marked other than "natural", or items 23a or 28a-f show umatic event, the Modeal Examiner must be notified a	by Funeral Director	11. Maritat Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? !∏No		Was Decedent of Yes, specify C			ecify Yes or No- Rican, etc.)		Race - Ameri Black, White pecify: B1	etc.	
215-00	thin 72 hou e. en "nature Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-	4or 5+)	(Give	dent's Usual Ockind of work do. DO NOT use ref	cupation ne during mos tired)	st of worki	ng		of Business/Ir	dustry	
Maryland 21215-0036	l be filed within hal Hygiene. ed other than ' event, the Ma	Be	9th 17. Father's Name (First, Middle, Last,)		Home	naker			(First, Middle,	Maiden Su	Home		
Maryla	d 2 should be and Ment 7 is marked traumatic e	Ç	Jacob Rynes Bertha Matthews 19a. Informant's Name/Relationship (Type, Print) Althea Tilghman/Daughter Bertha Matthews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 22919 Thawley Road, Denton, MD 21629									o Code)		
Baltimore, I	permit. Pages 1 and 2 should be Department of Heelih and Menta Importent: If Item 27 is marked any injury or other traumatic and DOCE.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from S	20b. F	Place of Disponentery, cremetery, cremetery	esition (Name of matory or other)	place)		9,2006		tion - City or T		
Baltir	permit. P Depertme Importen any injur		Spring Grove Cemetery Feb. 9,2006 Denton, MD 21. Signature of Emeral Cervice Unisee Spring Grove Cemetery Feb. 9,2006 Denton, MD 22. Name and Address of Facility Spicer-Mullikin Funeral Homes, Inc. 1000 N. DuPont Pkwy., New Castle, DE 19720											
	Pnysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. DEMENTA										tween Death	
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (d	r as a consec	uanca of)								
O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							d. Date of delik		Year		
rds, P.	quires that t n signed by uld be deta	٥	Part II. Other significant continuous continuous to dealin out not resulting in the andenying cause given in react.									./	death? Unknown	
Records,	The law requires that the ete hes been signed by th page 2 should be detache	Completed		-15.						24a. Was autop perfor 1 Yes	med?	24b. Were aut prior to c death? 1 ☐ Yes	opsy findings ompletion of a	available cause of
ita	ysician: The is certificate hi director, page	Be	25. Was case referred to medical examiner?			200000000000	1		e of Deat	h (Check only o	ne)			
Division of Vital	ding Ph h. After th funeral	tlon: To								dome 5 x esidence 6 Other (Specify) 28d. Describe how injury occurred				
Divisi	in Stage	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, face building, etc. (Specify)								ral Route Nur	nber,		
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical (hysician: To the miner: On the ba and mann	sis of examina									s)
)	To the within 2 To the complei	Σ	29b. Signature and title of certifier					cense number	8/5			signed (Month		
	50		30. Name and address of person who	H M	PULL	mom	Print) 9/2	01	MARI	1055	REET	- DE	~ion/	MD
	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 7 2006	32. Re	gistrar's Sign	ature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1)

		•	1 - For State Registrar	State of Marylan		artment of H rtificate of L		ientai mygie Reg.	7000	05679	
Г	Physici	Decedent's Name (First, Middle, Last) Physician The state of th						2. Date of Death Month	Day Year	3. Time of Death	
H	/Medic	al.						February	4 2006 4c. County of Deat	6:13 A M	
	Examin	er	4a. Facility Name (If not institution, give street and number) Greater Laurel Health & Rehab. Ctr. Laurel							" George's	
	Funeral Director		5. Social Security Number 6. S 577-46-4373	ex 7. Age (In yrs. 68		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) Jun. 27,	9. Birt	hplace (State or Foreign buntry) ash., DC	
	yland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside								
	e Marfs	ctor	DC			Wa	shington			1 X Yes 2 □ No	
	vith th	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?	
	eath v	erai	825 Adrian	St., S.E. 12. Was Decedent Ever in U	S 13		0019	acify Vas or No.	United 14. Race · Ame	States	
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Itams 23a or 28a-f show is marked other than "natural", or Itams 23a or 28a-f show aumatic avant, Ita Modical Examinar matthe modified at	by Funerai	1 Never Married 2 Married 3 Widowed 4 X Divorced	Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 【XNo		Rican, etc.)	Black, Whit	e, etc.	
2	72 ho 'natur	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	dent's Usual Occupa	ation Juring most of work	ing 16	b. Kind of Business	Industry	
121	within ane. Ihan "	Completed	Elementary/Secondary (0-12)	ementary/Secondary (0·12) College (1·4or 5+) life. DO NOT use retired)							
2	filled y Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)		1	Compute	r Analyst 18. Mother's Name	e (First, Middle, Ma	Goveri iden Sumame)	nment	
a	m = 0 %	To Be	Unknown					Mary C.	Washingt	on	
Maryland	shou and M s mar		19a. Informant's Name/Relationship (19b. Maili	ng Address (Street a	and Number or Rura		ity or Town, State,		
	and 2 saith a n 27 is		Joyce C. Love						n., DC 200		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic as		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Mellioval nom State		osition (Name of matory or other plac National	Cem. 2/1	.3/06	c. Location · City or Triangle	e, VA	
Balt	permit. Departimport any inj		21. Signature of Funeral Service Licer	Stewar I	II 22	2. Name and Addres			uneral Ho Wash., Do		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death								
	Physician		Immediate Calus (Final disease or condition resulting in death)								
	/Medical Examiner	Examiner	Due to (or as a consequence of):								
			Sequentially list conditions,		Pneumonia Due to (or as a consequence of):						
	uted J ansit		Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events								
ó	tificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a consequence of):							
68760,	ate be nysicia he bu	fedical		d							
_		Med	IF FEMALE:		0.00			0,000			
.O. Box	at the death certile by the attending	by Physician/N	23b. Was decedent pregnant in the past 12 months? 1						23d. Date of delive		
Д.	s that ned b e deta	y Pł							23e. Did tobacco use contribute to the cause		
g	w requires that been signed k should be det							1 🗌 Yes	2 □ No 3 □ P	robably 4 🕅 Unknown	
l Records,	The la	Completed						24a. Was an autopsy performs	prior to	utopsy findings available completion of cause of s 2 No	
/ita	Physician: this certificaral director, p	Be (25. Was case referred to medical examiner?	I tait-l				h (Check only one)			
<u></u>	Physi this c	2	1 ☐ Yes 2 🛣 No 27. Manner of Death		ER/Outpatie				ce 6 Other (Spe	ecify)	
- H	eur eur	tion	1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Worl	yat k? Yes 2 □ No	28d. Describe now	. Describe how injury occurred		
Division of Vital	deat deat ctor:	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. L						Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hospital or A within 24 hours after To tha Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or in	th occurred at the tin restigation, in my or	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)	
	within To th compl	Me	29b. Signature and title of certifier	d. Date signed (Mon	th, Day, Year)						
			D42580							Februarly 7, 2006	
	(5)		30. Name and address of person where Parmjit S. Au			Print)	Rd., #13,			20710	
	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 9 200	2. Registrar's Sign		de					

			1 - For State Registrar	State of Mar	yland / Dep		Health and		_	05680			
A			1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea Month		3. Time of Death			
	Physici /Medi Examir	cal	Ethel Irer	ne Williams re street and number)		4b. Cily, Town,	or Location of De	2		006 9:25 A M			
			Manor Care N	ursing Home			Silver S	pring	M	ontgomery			
161.	Funeral		Social Security Number 6.	Sex 7. Age (In yrs. last birthday)		If Under 24 H	rs. 8. Date of Birth	1	Birthplace (State or Foreign Country)			
	Director		5/8-28-5590 Usual Residence of Decedent	1□ M 2□XF	85 Yrs.			Apr. 14		Wash., DC			
	Marylar a-f ehow	tor	Maryland Prince	George's	Oc. City, Town or Lo		Marlboro			10d. Inside City Limits 1 Yes 2 No			
	in the	Directo	10e. Street and Number			10f. Zip Code		1	log. Citizen of Wh	at Country?			
	15 wi	ai	4902 Woodfor	d Lane			20772		Unit	ed States			
	r dea	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Black.	American Indian, White, etc.			
9600	ours afte ral', or it Examin	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1□Yes 2⊠No			Specify:	Black			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 show ship highty or other traumatic event, the Medical Examinar must be nutilled at 2008.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of v	vorking	16b. Kind of Busi	ness/Industry			
	Hygier Hygier ther th		12th			Bake				overnment			
Maryland	be fit d oth	Be	17. Father's Name (First, Middle, Las.				18. Mother's N	lame (First, Middle,	Maiden Sumame)				
<u>Y</u>	Men Men Marke Marke	ပ	Aloysiu						e Harrod				
Jar	2 sh and le rr		19a. Informant's Name/Relationship			•		Rural Route Numbe					
	and lealth m 27		Jacqueline V. Wi				ford Lan	e, Upper					
0	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 Burial 2 Cremation 3 [20b. Place of Dispo cemetery, cre	matory or other pla	ace)	Date	20c. Location - Ci	ity or Town, State			
Ë	Pa tmen tant:		4 □ Donation 5 □ Other (Special					11/2006	Lan	dover, MD			
Baltimore,	permit. Depertitmport. Import. eny inj.		21. Signative of Funeral Service Licens 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20										
			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Interval Bet										
	Physician		Immediate Gause (Final disease or condition resulting in death) a. Cardiorespiratory acrest Due to (or as a consequence of): b. Coronary artery disease Due to (or as a consequence of):										
	/Medical		resulting in death)	Due to (or as a c	onsequence of):	77 - 707	Jan de	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
	Examiner		Coguestially list conditions	, COLO	nary as	tery.	diseas						
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events c.										
	ate be executed hysicien and he burial-transit	Examiner	Cause (Disease or injury that initiated events	c									
ó	e exe ien a		resulting in death) Last	Due to (or as a c	onsequence of):								
3760,	ysic he bu	icai	•	d					-				
89	leeth certificat ettending phy I for use as th	Med	IF FEMALE:										
XO	th ce tendi	an/I	23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2 [⊒Ectopic pregnan	cv		23d. Date	,			
.O. B	the the	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□ Pregnant at tim 9□ Unknown		Other (specify)			Montr	n Day Year			
<u>α</u>	that the		Part II. Other significant conditions	contributing to death but r	not resulting in the L	inderlying cause o	iven in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?			
ds,	signed d be det	d by	DH 47	es 2 No 3									
Ö	w requir been si should	ete	100	The precional					00.14				
Records,	The law	Completed	ore m	entia				24a. Was a autop perfor	sy prie	ere autopsy findings available or to completion of cause of ath?			
Vital			25. Was case referred to medical				26 Place of F	1 ☐ Yes Death (Check only or		Yes 2 No			
5	Physician: this certificanal director,	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outpatie	nt 3 DOA O	ther */	g Home 5 Resid		(Sacción)			
ō			27. Mapher of Death	28a. Date of Injury	28b. Time o				ow injury occurred				
on	nding F th. : After s funer	atio	Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	'e <i>ar)</i> Injury		ork?]Yes 2.∏No						
Division	ospital or Attending hours after death. uneral Director: Afte ly filled in by the fune	Certification:	2 Suigide 6 Could not be					28f. Location (S City or Tow		or Rural Route Number,			
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a Certifier 1 Certifying P	hysician: To the best of r	niy knowledge, deal	th conumed at the	time, date and bit	and due to the n	ausa(s) and man	har as stated.			
	n 24 n 24 ne Fu	edicai	(Check only 2 Medical Exa	miner: On the basis of ex and manner state	kamination and/or ir d.	ivestigation, in my	opinion, death or	ccurred at the time, o	late and place, an	d due to the cause(s)			
	To the Tourier Comp	ž	29b. Signature and title of certifier	7	110	29c. Licer	nse number	4		(Month, Day, Year)			
			I MANGE	rul	MX	100	05536	2	2-3	3-06			
0	(6)		30. Name and address of person who	completed and of dear	th (Item 23a) (Type	Print) /R	ind SE	ega,	14,01	a Je			
_	(nes meen	1 40/	cast	fe fige	2011	+ KO	CRUILLE	100 COR 5			
	Sta Regist		31. Date filed (Month, Day, Year)		Signature	all a							

			For	State of M	aryland / Dep			nd Mental Hyg	gieņe	6 05681
			State Registrar		Ce	rtificate of	Death		Reg. No. UU	0 0 0 0 0 1
. 3	Physicia	an	1. Decedent's Name (First, Middle, La					2. Date of Dea Month Februa	Day	Year 006 3:00 P M
1	/Medic	al	Andrew Wilso			4b. City, Town, o	r Location of I		4c. County	
14	Examin	er	4a. Facility Name (If not institution, given Southern Mary1			40. Oity, 10411, 0	Clinto			nce George's
	· · · · · · · ·		5. Social Security Number 6. S	Sex_ 7. A	ge (In yrs. last birthday	If Under 1 Year	If Under 24	Hrs. 8. Date of Birt		_
	Funeral Director		579-76-8586	1 □ ¥M 2 □ F	49 Yrs.	Months Days	Hours	Nov. 25	h y. Year) 5, 1956	9. Birthplace (State or Foreign Country) South Carolina
100	P .		Usual Residence of Decedent		10c. City, Town or L					10d. Inside City Limits
	arylar show	_	10a. State 10b. County		Toc. City, Town or L					1 XYes 2 No
	Ne M	ecto	Maryland Prince 10e, Street and Number	George's		Forestv:	IIIe		10g. Citizen of W	/hat Country?
	a or	급	3400 Pumphre	y Drive		Toil Esp codo	2074		-	ed States
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or iteme 23a or 28a-f show event, the Medical Examinat must be notified at	Funeral Director	11. Marital Status	12. Was Deceden	Ever in U.S. 13.	Was Decedent of H		n? (Specify Yes or No- Puerto Rican, etc.)	- 14. Race	- American Indian,
(0	r Her	Fur	1X Never Married 2 Married	Armed Forces		1 ☐ Yes 2 XNo		Puerto Rican, etc.)	Specify	African
21215-0036	rai', c	i by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:						American
5-	72 h "natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dec	edent's Usual Occup e kind of work done DO NOT use retire	oation during most o	of working	16b. Kind of Bu	siness/Industry
121	within	ld m	Elementary/Secondary (0-12)	College (1-4or	5+)	Carpenter			Pri	vate
d 2	Hygi ther nt, 1		17. Father's Name (First, Middle, Last			our pencer.	- _	s Nam <i>e (First, Middle,</i>		
an		To Be	Arthur Smith	, Jr.				Sarah Lo	ouise Wi	1son
Maryland	s 1 and 2 should be it Health and Mental item 27 le marked oother traumatic eve	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address (Street	and Number	or Rural Route Numbe	er, City or Town,	State, Zip Code)
	5 # 2 F		Patricia Smith	Wright/Si	ster 34	400 Pumph:	rey Dr.	, Forestv	ille, MD	20747
ore	ges 1 ar it of Hea If item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [Removal from State		position (Name of ematory or other pla		Date		City or Town, State
Ë	ertment of crtant: If it injury or o		4 ☐ Donation 5 ☐ Other (Speci	fy)	Lee's (Crematory		2/15/06 Stewart 1		ton, MD
Baltimore,	permit. Pages. Depertment of Pimportant: If ite		21. Signal re of Funeral Service Lice	eura X I	Π					, DC 20019
			23a. Part. Inter the disease, or con sho k, or heart failure. List only	nplications that cause one cause on each	ed the death. Do not e line.	ter the mode of dy	ng, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediat Cause (Final disease or Indition	_ a	0	vesC	IRR	hesis		Unknown
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):	+10				. //
		<u></u>	Sequentially list conditions,	b. Due to (or a	s a consequence of):	May E	>			Jank Mans
	ted nsit	n lu	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Hen	t.In C	**			anknows
Ć.	e be executed /sician and e burial-transit	Examine	resulting in death) Last	Due to (or a	s a consequence of):					
190	eath certificate be executed attending physician and for use as the burial-transit	ca		d						
89	Attending Physician: The law requires that the death certifical death. death. sctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE:							
Box	ath ce Itendi	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnance	;y			te of delivery nth Day Year
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant 9☐ Unknown		Other (specify) _				
P.0	that the	P H	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause g	ven in Part I.	23 <i>e</i> . Did t	tobacco use cont	ribute to the cause of death?
Records,	puires that n signed t uld be det	p	Human I	MAVUR	Delici	1 pm	, sec	22e 10	Yes 2□No	3 Probably 4 Unknown
Ö	s been si	Sete	HUDOTEN.	502		7		24a. Was		Were autopsy findings available prior to completion of cause of
	The fa	mo	Van Carlita					perfo	ormed?	death? 1 🗆 Yes 2 🗆 No
ia	lan: ntifica ctor, p	Bec	25. Was case referred to medical examiner?		/			of Death (Check only	one)	
>	hysic his ce il dire	2	1 □ Yes 2 D No	Hospital: 1 Hipa		ent 3 DOA		sing Home 5 Resi		
n c	ing P	on:	27. Manner of Death 1 Watural 5 Pending	28a. Date of Ir (Month, L		W	ork? ⊡Yes 2.∐N		how injury occur	180
Division of Vital	death death ctor: y the	ficat	2 Accident investigati 3 Suicide 6 Could not determine	be 28e. Place of	njury - At home, farm,			28f. Location (Street and Numb	per or Rural Route Number,
Σ	afor after I Dire	Certification:	4 Homicide	building,	etc. (Specify)			City or 10	wn, State)	
	To the Hospital or Attending Physician: The law requivithin 24 hours after death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should	Medical (st of my knowledge, de of examination and/or stated					anner as stated. and due to the cause(s)
	othe	Mec	29b. Signature and title of certifier			29c. Licer	nse number			d (Month, Day, Year)
	- > - 0		> //	Dut	Annual Control of the	500	154		Febu	10,4706
0	(1)		30. Name and address of person	o completent cause o	f death (Item 23a) (Typ	e, Print) Ar	astoo	Yazdani, M		
1			986 Creons	Ale	1-41 3	il ver SE	251,5	MD 20	905	
4	St. Regist	ate rar	31. Date filed (Month, Day, Yell) FEB 0 9 200		strar's Signature	ule				

1 - For State Registrar 1. Decedent's Name (First,
1. Decedent's Name (First,
MANIE

Physicia /Medic Examin

Funeral Director State of Maryland / Department of Health and Mental Hygiene

•	3	0	0	\cap	6	\cap	2000
	Reg.	No.	U	U	0	U	0

1 - State Registrar	Reg	05682									
1. Decedent's Name (First, Middle, L	.ast)				2. Date of Death		3. Time of Death				
MANIE	WHI:	TTINGTON	ī		FEBRUARY	Day Year 2006	6:40 P M				
4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town	, or Location of Death	1	4c. County of Deal					
CHEASPEAKE HOS	PICE HOUSE		LINTH	LCUM		ANNE AR	RUNDEL				
		. last birthday)	If Under 1 rea		8. Date of Birth (Month, Day, Y	(ear) 9. Birt	thplace (State or Foreign				
579-32-5347	1□ M 2⊠F 80	Yrs.			MAY 27 1		HINGTON, DC				
Usual Residence of Decedent 10a. State 10b. County	10c C	City, Town or Loca	ation				10d. Inside City Limits				
,						12 Yes 2 No					
10e. Street and Number	KUNDEL L	INTHICU			1.0	0.00					
	DOAD		10f. Zip Code 2109		109	U.S.A.	ountry?				
817 CAMP MEADE	12. Was Decedent Ever in t	11 S 113 W		f Hispanic Origin? (S	pocify Vas or No-	14. Race - Ame	nican Indian				
1 Never Married 2 Married	Armed Forces?	0.3. 13. W	Yes, specify C	uban, Mexican, Puert	o Rican, etc.)	Black, Whit					
3 ∰Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 [□Yes 2XŪN	o Specify:		Specify:	BLACK				
15. Decedent's		16a. Decede	ent's Usual Occ	upation	16	b. Kind of Business	/Industry				
(Specify only highest g	grade completed) College (1-4or 5+)	(Give ki	ind of work doi O NOT use reti	ne during most of wor red)	king		,				
Elementary/Secondary (0-12)	4 yrs	TEA	CHER			GOVERNMEN	ΙΤ				
17. Father's Name (First, Middle, La.	st)			18. Mother's Nan	ne (First, Middle, Ma	iden Sumame)					
JAMES A. ROA	NE			ALICE	B. QUE	EN					
19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St									
CAROL LEAK/DA	UGHTER	2219 COLUMBIA PLACE LANDOVER, MARYLAND									
20a. Method of Disposition		20b. Place of Disposition (Name of Date 20c. Location - City									
1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	□Removal from State F'	FT. LINCOLN CEMETERY 2/10/2006 BRENTWOOD									
21. Signature of Funeral Savon Lic	CONTRACTOR OF THE PARTY OF THE			fress of Facility J.							
	-	74	74 LAN	DOVER ROAL	LANDOVER	, MARYLANI	20785				
23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the dea	ath. Do not enter	the mode of o	t.	Approximate Interval Between						
Immediate Cause (Final	CEREBROVAS	CIII AD A	CIDENT				Onset and Death				
disease or condition resulting in death)	a. Due to (or as a conse		CIDENI								
	DECUBITUS	,									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse										
Cause (Disease or injury that initiated events	C										
resulting in death) Last	Due to (or as a conse	equence of):									
	d										
15.55	257										
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	nancy	Ectopic pregna	2011		23d. Date of de	livery				
in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of		Other (specify)			Month	Day Year				
9 Unknown											
Part II. Other significant conditions	contributing to death but not re	sulting in the und	derlying cause	given in Part I.	23e. Did toba	cco use contribute to	the cause of death?				
				····	1 ☐ Yes	2⊠No 3□P	robably 4 □Unknown				
					24a. Was an	24b. Were a	utopsy findings available completion of cause of				
					autopsy performe	ed? death?					
25. Was case referred to medical				26. Place of Des	1 Yes 2 Lath (Check only one)	XNo 1 ☐ Yes	s 2 ½ □ No				
examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA			ce 6 X Other (Spe	outy) Hospice				
27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. lr			ne 5 Residence 6 DOther (Specify) Hospice 8d. Describe how injury occurred					
1 ANatural 5 Pending 2 Accident investigat		Injury		ronk? □Yes 2□No							
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	280. Place of injury - At i	home, farm, stree	et, factory, offic	ce	28f. Location (Stre	8f. Location (Street and Number or Rural Route Number,					
4 D Hornidae	building, etc. (Spec	uy)			City or Town, State)						
29a. Certifier 1 Certifying	Physician: To the best of my kr	nowledge, death	occurred at the	time, date and place	, and due to the cau	to the cause(s) and manner as stated.					
(Check only 2 Medical Ex	eminer: On the basis of examin and manner stated.	nation and/or inve	estigation, in m	y opinion, death occu	irred at the time, date	ne time, date and place, and due to the cause(s)					
29b. Signature and title of certifier	1		29c. Lice	ense number	290	29d. Date signed (Month, Day, Year)					
Douglas Us	a loter un)	DC	1583	2	2/8/0	4				
30. Name and address of person wh	to completed cause of death (Ite	em 23a) (Type, P		1-00		1-10	U				

DHMH 17 Rev 1/2001

State

Registrar

DOUGLAS VANZOREN M.D.

FEB 0 9 2006

31. Date filed (Month, Day, Year)

32. Registrar's Signature

1011 NORTH CAPITOL ST. N.E. WASHINGTON, DC 20002

		For State Registrar	State of Maryland /	•	irtment of H tificate of L			ieņe _{og. No.} () (06	05683
ELLÉ		1. Decedent's Name (First, Middle, Last)					2. Date of Deat		Vaar	3. Time of Death
Physicia /Medic		Anna Cecelia Wash	ington				February	7 3, 20	00 ⁶ 6ar	12:55p м
Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Deat	h		ty of Death	
	ç.	Southern Maryland			Clinton				e Geo	
Funeral Director		219-28-6308	M 2⊠F 7. Age (In yrs. last t	Yrs.	If Under 1 Year Months Days	Hours Min		^{Year)} 1928	9. Birthp Cour Wald	place (State or Foreign orf, MD
and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Lo	cation				1	I0d. Inside City Limits
daryl f sho	0	MD Prince Ge	orges Capit	o1 H	leights					1X∑Yes 2 ☐ No
the I	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen o	f What Cour	ntry?
a with	ā	1105 Alverton St.			207	43		US.	A	
death ms 2:	Funeral		2. Was Decedent Ever in U.S.	13. \	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (5	Specify Yes or No-		ace - Americ	
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In the stand of the transmitter of the transmitter of thems 28 and 28 an	Þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify Cuba □ Yes 21X No	Specify:	to Rican, etc.)		ack, White,	
2 hou	Completed	15. Decedent's Educ		a. Deced	lent's Usual Occupa	ation	4	16b. Kind of	Business/In	dustry
hin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. l	kind of work done of OO NOT use retired,	furing most of wo)	rking			
giene giene	М	8th		Нοι	sewife			Priva	te	
e filed within al Hygiene. I other than vent, Ire Ma	Be (17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, i	Maiden Suma	am <i>e)</i>	
should be and Mental s marked o	70	Roosevelt Bris	coe			Rache1	Short	er		
s 1 and 2 should if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Typ					ural Route Number			
1 and 2 Health tam 27		Valarie Washingtor	/ Daughter 6	5109	Dominica	n Dr., S	pringfie.	Ld, VA	22152	2
of He		20a. Method of Disposition	como	of Dispo	sition (Name of natory or other place	9)	Date	20c. Location	n - City or To	own, State
Page nent int: ff		1 ☑ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	MD Ve	tera	ns Cemete	ery 2/1	4/2006	Chelte	nham,	Maryland
permit. Pages Department of Himportant: if Ita any Injury or of once.		21. Signature of Funeral Service License	hall		Name and Addres		J.B. Jenk Landove		neral 2078	_
77.14		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. D	o not ent	er the mode of dying	g, such as cardia	ic or respiratory arr	est,		Approximate Interval Between
Physician		Immediate Cause (Final			512					Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequence		>1 ->					
Examiner		CANTONIA MANTANTON LA COLORADA	UZIHAZ		PACT	INFE	CTION		-	
	Jer	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence		, , , , - ,					
uted id ansit	Examine	Cause (Disease or injury that initiated events	CELEBRA	D V	TS CULA	n A	ecine	NT		
exec en ar rial-ti	EX	resulting in death) Last	Due to (or as a consequent	ce of):						
cate be executed only sicien and the burial-transit	dical									
ng ph	Med	IF FEMALE:						1		
eath certific attending p	Physician/Me	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	ath 3⊡	Ectopic pregnancy				Date of deliv Month	
ne dea the at hed fo	sici	in the past 12 months?	4☐ Pregnant at time of death 9☐ Unknown		Other (specify)			ľ	MOULL	Day Year
net the de d by the letached	Phy	9 Unknown								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Infector: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions con	tnbuting to death but not resulting	g in the u	nderlying cause give	en in Part I.		bacco use co es 2□No		the cause of death? bably 4 Winknown
s be	Completed						24a. Was a	ın 24t	. Were auto	opsy findings available
The lav te hes	Eo						autop: perfor	med? 2 No	death?	
ictan: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of De	eath (Check only or			
ysician: The is certificate his director, page	To B	examiner?	ospital: 1 Inpatient 2 ER/	Outpatier	nt 3 DOA Othe	ar	Home 5 ☐ Resid		Other (Speci	fy)
g Physier this		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28I	o. Time o	28c. Injun Won	at	28d. Describe h	ow injury occ	curred	
uttendin death. ctor: Afr y the fur	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(, 25)	,,		Yes 2 □ No				
l or Attending after death. Director: Afte	t t	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (S City or Tow		mber or Rur	al Route Number,
rs after al Direction	Certification:		3,							
To the Hospital or Attending in within 24 hours after death or To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Examination	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, deat and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the courred at the time, o	ause(s) and date and plac	manner as : e, and due i	stated. to the cause(s)
Vithic the To the To the comp	M	29b. Signature and title of certifier	1.		29c. License	e number	-	29d. Date sig	ned (Month,	Day, Year)
		> Alula	ely UM		100	6165	2_	02	1061	2006
10		30. Name and address of person who co	mpleted cause of death (Item 23	a) (Type,		0103		1.1	1-1	
Sta	ate.	SUITE 750,	Λ .	TAV		, a	INTON	, M.	MEYL	2006 Anm, 207
Regist		FFR 0 9 2006	Bloke K.	has	R)					

			For State Registra/MEND#1perMD2/10 1. Decedent's Name (First, Middle, Last)	State of Mar	yland / Do	epartment Certificate				giene Reg No.	6 ()568L	
	Physici		1. Decedent's Name (First, Middle, Last)	Helen	G. R.W.	right			2. Date of Dea Month	Day	Year	3. Time of Death 2:30 A M	
E	/Medio		4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or Locat	ion of Death	Frunda	4c. County			
	Examir	ier	Kline Hospice Hous				t Airy			Frede	rick		
	Funeral		5. Sociel Security Number 6. Sex	7. Age (In yrs. last birth	day) If Under	1 Year If Un	nder 24 Hrs.	8. Date of Birt (Month, Da	th Vear	9. Birthp	elece (Stete or Foreign	
-57	Director		577-01-2230 ¹	M 211 F	92 Y	Months	Days Hou	IIS WIII.	Aug. 1	, 1913	1913 Virginia		
	p.		Usuel Residence of Decedent	1.	10 - C't - T						1	0d. Inside City Limits	
	anylar ahow	_	10a. State 10b. County		Ioc. City, Town	or Location						1 StYes 2 □ No	
	8a-f	octo	MD Montgomer	У	Chevy C		0-1-			10g. Citizen of V	Mhat Cour	2002	
	with th	吉	10e. Street and Number			10f. Zip	815			United		·	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f ahow thit, the Medical Examinar must be notified at	by Funeral Director	5303 Willard Avenu	1.0 2. Was Decedent Ev	er in IIS			Origin? (Spe	ecity Yes or No			ean Indian,	
	lter de	un.	11. Marital Status 1 Never Married 2 Married	Armed Forces?		13. Was Deced If Yes, spec	offy Cuban, Me	xican, Puerto	Rican, etc.)	l l	k, White,	etc.	
36	rs aff	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 KNo Spe	city:		Specify	Whi	te	
ğ	72 hours after dea *natural; or Items orcel Examinar m	per	15. Decedent's Educ	ation	16a. E	Decedent's Usua	al Occupation			16b. Kind of Bu	usiness/In	dustry	
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21215-0036	giene giene	Completed	11		_	cretary				C & P T		hone	
	be file ital Hy od othe event.	Be (17. Father's Name (First, Middle, Last)				18. N			, Maiden Sumam	10)		
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	s 1 and 2 should be filed within 72 ho I Health and Mental Hygiene, item 27 is marked other than "natur other traumatic event, the Microsi		Gloria Stepp / Dau	ignter ————					Date	20c. Location -			
ore	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery	Disposition (Nar , crematory or o	ther place)	1					
<u>E</u>	tant:		' 4 ☐ Donation 5 ☐ Other (Specify)		Ft. Li					Brentw			
Baltimore,	Departiment Departiment Departiment Departiment Departiment Department Depart		21. Signature of Funeral Service License							wler's S on DC 20		Inc.	
	40284		23a. Pert1. Enter the disease, or compli	estings that saying th	ho doeth. Do se						010	Approximate	
			shock, or heart failure. List only or trimediate Cause (Final	e cause on each line			2.			DISEA		Interval Between Onset and Death	
3760,	/Medical Examiner Asician and he purial-transit	ilcai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a	consequence o	f): f):						/	
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death	3 □Ectopic p 5 □ Other (sp					te of delive	ery Day Year	
Records, P	v requires that th been signed by should be detacl	þ	Part II. Other significant conditions con	•	not resulting in	the underlying o	cause given in F	Part I.				he cause of death? bably 4 2 Unknown	
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>	S D	101	1 ☐ Yes 2 No		t 2□ER/Out			Nursing Ho		idence 6 🖾 Oth		WHO HOUSE	
o uo	fune		27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Yeer) 28b. Ti	ime of 2 jury M	28c. Injury at Work? 1 Yes	2 No	28d. Describe	how injury occur	red		
Division of	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, far (Specify)	m, street, factor	y, office			(Street and Numi own, State)	ber or Rur	al Route Number,	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical (29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of ner: On the basis of a and manner stat	examination and	death occurred For investigation	at the time, dan, in my opinion	ite and place, i, death occur	and due to the red at the time,	cause(s) and m , date and place,	anner as a	stated. to the cause(s)	
	Fo the Forthin Forthin Complete	Me	29b. Signature and title of certifier			29	c. License num	nber		29d. Date signe	d (Month	Day, Year)	
)			150000 / (1/2 1	1.0.	And and an artist of the second	DIC	0587		FEBRU.9R	4 8	, 2006	
	16		30. Name and addres of per on who co	empleted cause of de	ath (Item 23a) (Type, Print)	(-	tucpice.	05 F	FEDERIC	K C	00,000	
			GEORGE 1. ShITH	L.D.	MEDICAL	DIREC	TOR: 51	16 TRAIS	- 1908	· FREDE	cick,	MD. 21701	
	St Regist	ate Irar	31. Date filed (Month, Day, Year) / FFR 0 9 20	32. Registra	r's Signature	Sperke	,			,		ho. 21701	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 1009 Norma Katherine Winter 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Region & Malian Conker Sali Shere teningula-Wiconless 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 17,1913 Pennsylvania Min. Hours 1 □ M 2 X F 92 Director 173-34-8157 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 end 2 should be filed within 72 hours after death with the Marylan ment of Heelilb end Mental Hygiene. ansit if item 27 is marked other then "neture!, or itame 23a or 28a-1 ehow usy or other theumatic event, the Madical Examinat must be notified at ury or other treumatic event, the Madical Examinat must be notified at 1 Yes 2 □ No Directo Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21801 1613 Camden Ave Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 3 Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sara Anna Auman Armstrong Quigg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Judith Sensenbrenner/Daughter 1613 Camden Ave. Salisbury, Maryland 21801 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Sunnyside Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/11/06 Bald Eagle Township, Depertment of Important: If eny injury or gode. 4 □ Donation 5 □ Other (Specify) Pennsylvania 22. Name and Address of Facility Holloway Funeral Home P.A. 501 Snow Hill Rd. Salisbury, Maryland 21804 21 Signature of Funeral Service Licensee CFSP Javie 4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEPUTIC - Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ò Month Day 4 Pregnant at time of death 5 Other (specify) signed by the e P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, MERTENSION cete hes been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? USTEPPODOSIS 24a. Was an certificete hes autopsy performe CROUT 1□ Yes 1 Yes 2 X No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Certification: To After this 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 TYes 2 □ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) de D-0060515 30. Na e and address of person who completed cause of death (Item 23a) (Type, Print) M.THIMMANAYAPAM 31. Late filed (Month, Day, Year) 0 614 B EASTERON SHURE DR SALISBURY MD 32. Registrar's Signature State EB 0 8 Registrar 2006

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar						t of H	ealth a		ental Hyg	_	6	05686	
` :	Physici	an	1. Decedent's Name (F		7							2. Date of Deal	h Day	Year	3. Time of Death	
100	/Medic	al	Edward C. 4a. Facility Name (If no			n <i>ber</i>)		4b. City	Town or	Location of	Death	JEbruc	4 County		06 1711 M	_
	Exami	er	PerINSULA		1 Mea		renter			1/13/1				com		
	Funeral Director		5. Social Security Number 218–20–345 Usual Residence of De	5	ex X IM 2□ F	7. Age (In yrs	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, May 11,	Year) 1927	9. Birth Cor	nplace (State or Foreign untry) PA)
	yiand 10w			b. County		10c. C	City, Town or Lo	cation							10d. Inside City Limits	
	e Mar	Director	MD	Wicomic)	Sa	alisbur	У							1⊠Yes 2□No	
	with th	Dire	10e. Street and Numbe					10f. Zip				1	0g. Citizen of V		untry?	
	ma 23	Funeral	718 Booth	St.	12. Was Dece	dent Ever in	U.S. 13.	Was Dece	2180 dent of His		in? (Spec	cify Yes or No- lican, etc.)		SA e · Amer	ican Indian,	_
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<u>2</u>	n 72 hours natural;	etec	15 (Specify o	Decedent's Ed	lucation de completed)		16a. Dece (Give	dent's Usu kind of wo	al Occupa rk done d	tion furing most	of workin	g	16b. Kind of Bu	siness/1	ndustry	_
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yland	Men Men arke	To	Nate Whitt	ington						Este.	lla 1	Lankford	i E			
Mar	C/ 40 70 10		19a. Informant's Name									Route Number		State, Z	ip Code)	
	s 1 and if Health itam 27 other to		Margaret B		daughte		405 S Place of Dispo	Wan R	ne of	Salis	bury	MD_218	301 20c. Location -	City or 1	Town, State	_
Baltimore,	it. Pages 1 rtment of Hi rtant: If itan		1 ⊠Burial 2 □ C 4 □ Donation 5 [cemetery, crei		•	· 1	/11/:		Salisb			
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ī,	w requires thet the d been signed by the should be detached	by Pt	Part II. Other significar	nt conditions co	ontributing to de	ath but not re	sulting in the u	nderlying o	ause give	n in Part I.		23a. Did tob	acco use conti	ribute to	the cause of death?	Ī
cords	equire en sig ould b		Chronic.	renal	failure	2	·					1 🗆 Ye	s 312No	3 Pro	bably 4 Unknown	J
d)	a ac	Completed	cellulit	is le	9							24a. Was ar autops	/ .	prior to ci	opsy findings available ompletion of cause of	
	page 1						_					perform 1 Yes 2	No 1	death?	2 🗆 No	
Vital		o Be	25. Was case referred examiner? 1 Tes 2 No		Hospital:	npatient 2	☐ ER/Outpatier	t 3 DC	Othe	-		Check on one e 5 ☐ Reside			4. 1	-
		T: T	27. Manner of Death	□ Bandina	28a. Date o		28b. Time of Injury		8c. Injury Work			3d. Describe ho			ny)	-
Vision	Attending r death. sctor: After by the fune	catlc	2 Accident	Pending investigation Could not be				М	1 🗆 Y	es 2□N	lo					
ž D		Certification:	4 Homicide	determined	286. Place buildir	ng, etc. (Spec						City or Town	, State)		ral Route Number,	
	To the Hospital or within 24 hours effection 24 hours effection to the Funeral Direction place of the following the filled in th	edical	29a. Certifier (Check only one) 2	Certifying Phy Medical Exam	illier: On the ba	best of my kn isis of examin per stated.	lowledge, death lation and/or in	occurred vestigation	at the time , in my op	e, date and inion, death	place, ar occurred	nd due to the ca d at the time, da	use(s) and ma ite and place, a	nner as	stated. to the cause(s)	
	To the within To the Comp	Me	29b. Signature and title	of dertifier				290	License	number		25	d. Date signed	(Month	. Day, Year)	
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,	2 m		30. Name and address	of person who	71	-		Print)	0	Rea		ale lie	10+		Salisbury	
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	Registr		F	FR 0 8 5	006	2000	M. P.	scall.	,							

			For State Registrar	Hygiene Reg. No	HUb	05687					
			1. Decedent's Name (First, Middle, Last)			·		2. Date of	of Death		3. Time of Death
	Physici /Medio		WILSIE IRENE	BISHOP	WATERS			Month		y Year 3 2006	0435 M
	Examir		4a. Facility Name (If not institution, give	street and number)	1 00	4b. City, Town, o	r Location of D			. County of Death	
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	Funeral		Social Security Number 6. Security Number		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of	f Birth n, Day, Year)	9. Birth	place (State or Foreign
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	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				1.	10d. Inside City Limits
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	a or	គ				10f. Zip Code	4		10g. Ci	tizen of What Cou	ntry?
	eeth mus	era	100 Greenlawn Lane	12. Was Decedent Ev	ver in IIS 13.1	21804 Was Decedent of H		7 (Specify Vec	r No	USA 14. Race - America	non Indian
40	lten i	Ę	1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 1 No	1	f Yes, specify Cuba	an, Mexican, Po	uerto Rican, etc	.)	Black, White,	
38	al', or	b	3X Widowed 4 Divorced	If Yes, Give Year or Dates:		I□Yes 2√X No	Specify:			Specify:	Black
21215-0036	within 72 hours after deeth with the Maryland ane. than "natural", or Iteme 23a or 28a-f ehow the Madigal Examiner must be notified at	ed	15. Decedent's Edu	cation	16a. Deced	lent's Usual Occup	ation		16b. K	ind of Business/In	
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21	d with	E	11th	College (1-401 3+	labor	er			do	mestic	
	be filed tal Hygid d other	Bec	17. Father's Name (First, Middle, Last)				18. Mother's I	Name (First, Mi			
<u>a</u>	Mental Mental arked o	ToE	WILLIAM EDWARI	BISHOP			MARY	ELIZABI	ETH JO	OHNSON	
Maryland	₹ P E E		19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailin	g Address (Street	and Number of	r Rural Route N	umber, City	or Town, State, Zip	Code)
	permit. Peges 1 end 2. Department of Health ar Important: If Itam 27 is any Injury or other tra-		Elizabeth Franklin/d	aughter	100 G	reenlawn	Lane -	Salishu	rv. Ma	rvland 21	804
Baltimore,	of He		20a. Method of Disposition	J	20b. Place of Dispo.	sition (Name of natory or other place		Date		ocation - City or To	
Ĕ	Peges nent of int: If It iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Coolspring		1	/13/2006	Gird	Netree M	larvland
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	sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events								
oʻ	en ar	EX	resulting in death) Last	Due to (or as a	consequence of):						
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99	ntifica ng ph as th	Jed	IE EE MALE.			-					11 - 22
Вох	thet the death certific ed by the ettending p detached for use as	Physician/Me	230. Was decedent pregnant	3c. If yes, outcome of 1 Live birth 2		Ectopic pregnancy				23d. Date of delive	ery
Ξ.	dea ded fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at til		Other (specify)			_	Month	Day Year
P.O.	et the	h.	9 Unknown								
ď.	signed be det	by 5	Part II. Other significant conditions cor	tributing to death but	not resulting in the ur	nderlying cause give	en in Part I.	23e.	Did tobacco	use contribute to t	he cause of death?
ğ	w require been si should I	Completed by	bouldwar 100			A 111		_	1 ☐ Yes 2	□No 3□Prot	pably 4 🗹 Unknown
သို	law r	ple	Caresro Vascu	A	3 trabi	Kidua 1	emple		Was an	24b. Were auto	psy findings available
æ	The ste h	ШО	Seizure disi	order.				1 Y	autopsy performed? es 2 1 No		mpletion of cause of
Division of Vital Records,	Physicien: The law this certificete has b rat director, page 2 s	Be	25. Was case referred to medical examiner?				26. Place of I	Death Check of		,	
>	nysic nis ce dire	To	1 Yes 2 No	ospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Oth	er: 4 🗆 Nursin	gHome 5□	Residence	6 ☐Other (Specif	(v)
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<u>\S</u>	er de recto	ŧ E	3 Suicide 6 Could not be determined	28e. Place of Injury	- At home, farm, stre (Specify)	eet, factory, office		28f. Locati	on (Street ar	nd Number or Rura	al Route Number,
ā	To the Hospital or Attending Physicien: The I within 24 Hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director. page	Certification:			//			0.,, 0	, Grate	-,	
	hou hou uner uner like		29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	ician: To the best of	my knowledge, death	occurred at the tin	te, date and pl	ace, and ous to	the cause(s) and marmar as s	tatad.
	the F the F the F	Medical	one)	and manner state	id.	esugation, in my 0	рилип, ина(п о	cuired at the t	ine, date an	u piace, and due ti	une cause(s)
	with To To	2	29b. Signature and title of certifier	· (100		29c. License	4			te signed (Month,	
	. 0					D00	60715		75	2582	000
	() Wit		30. Name and address of person who co	mpleted cause of dea	th (Item 23a) (Type,	Print)	mn o	1221			N=:
	٧.		S.A. Reza Jakli	100 tast (oroll St.	20112201	ס עיון	11001			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pégistrar	s Signature	0.00					

DHMH 17 Rev 1/2001

214-32-0426

Wilsie Waters

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	•	Certificate of Death	Reg: No: U5 U5 U5 U5											
	1. Decedent's Name (First, Middle, Last)	2. Dete Mon	of Deeth 3. Time of Death											
Physician /Medical	Sister Margaret Wolf	Febr												
Examiner	4a Fecility Name (If not institution, give street end number)	4b. City, Town, or Location of												
	St. Vincent Care Center	Emmitsburg	Frederick											
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. lest	birthday) If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. (Mor	of Birth oth, Dey, Year) 9. Birthplace (State or Foreign Country)											
Director	214-54-6257 1□ M 2☑ F 85		. 14, 1920 Maryland											
P >	Usual Residence of Decedent 10a. State 10b. County 10c. City, T	Town or Location	10d. Inside City Limits											
show	Too. County	OWN OF ESSERIES.	1√2 Yes 2 □ No											
be M		nitsburg	10g. Citizen of What Country?											
with the Marylar a or 288-1 show be notified at Director	10e. Street end Number	10f. Zip Code												
sath w	335 South Seton Avenue 11 Merital Status 12. Wes Decedent Ever in U.S.	21727	U • S • A •											
5-0036 72 hours after death with the Maryland natural", or items 23s or 28s-f show alcal Examinat must be notified at steed by Funeral Director	Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e	tc.) Black, White, etc.											
D36	1½ Never Married 2 ☐ Married 1 ☐ Yes 2½ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2√2 No Specify:	Specify:											
21215-0036 within 72 hours af de within 72 hours af glana. or than "netural", or the Medical Exam.		6e. Decedent's Usual Occupation	White 16b. Kind of Business/Industry											
21215-0 ed within 72 ho ygiana. er than "naturu nt, the Medical Completed	(Specify only highest grede completed)	(Give kind of work done during most of working life. DO NOT use retired)	Religious Community											
vithin iana. the Me	Elementary/Secondary (0-12)	Teacher	Daughters of Charity											
be filed tal Hygi d other event,	17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First,												
ylan Suid be Mental Mental Artc ev	Henry Wolf	Madeline N	assner											
Maryland d 2 should be file d 2 should be file th and Mental Hy 7 is marked oth traumatic event To Be (19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route	Number, City or Town, State, Zip Code)											
Ma nd 2 still the arritman	Sister Camilla Harant	333 S. Seton Avenue, Emmi	tsburg, MD 21727											
rre, Maryland 212, at and 2 should be filed wit if Health and Mental Hygiens them 27 is merked other the other traumatic event, the To Be Com	com	e of Disposition (Name of etery, cremetory or other place)	20c. Location - City or Town, State											
Dages ent of nt: If it	1 12 Burial 2 Li Cremetion 3 Li Removal from State		6 EMMITSBURG, MD 21727											
Baltimore, N pemit. Pages 1 and Department of Health Important: If Item 27 any Injury or other t pace.	1 & Burial 2 Cremetion 3 Chemoval from State ST. JOSEPH'S P.H. 2/22/06 EMMITSBURG, MD													
B P P P P P P P P P P P P P P P P P P P	John m Still	Judnation 5 Liuther (Specify)												
	23a. Part. Enter the disease, or complications that caused the death. sheck or heart failure. List only one cause on each line.													
Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death) e. Due to (on expected to the condition of	s a consequence of):	e acute 48hs											
the death certificate be executed by the attending physician and ached for use as the bunal-transit hysician/Medical Examiner	if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	s e consequence of):	20 yrs											
death death death id for id for id for	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Pert I. 23	b. Did tobacco use contribute to the cause of death?											
, P.O. BOX that the death cert ed by the attendin datached for usa y Physician/N			1 ☐ Yes 2 ☼ No 3 ☐ Probably 4 ☐ Unknown											
ords, P.O. Bo) requires that the death or een signed by the attend hould be datached for us eted by Physician/														
Records, he law requires the law requires the law spen signe age 2 should be completed by		24	a. Was an autopsy performed? 24b. Were autopsy findings available prior to											
2 × × ×			completion of cause of deeth?											
if Rec The law ata has page 2			1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No											
Vital Fidelan: The certificata rector, pag	25. Was case referred to medical	26. Plece of Deeth (Chec	k only one)											
Of Vita Physician: this certific ral director,	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ EF	VOutpetient 3□ DOA Other: 4₺ Nursing Home 51	☐ Residence 6 ☐ Other (Specify)											
Division of Vital to Attending Physician: I after death. Director: After this certificat d in by the funeral director, py:ertification: To Be Co	27. Menner of Death 28a. Dete of Injury 28	Bb. Time of 28c. Injury at 28d. De Injury Work?	scribe how injury occurred											
Attending F or death. ector: Atter by the funer iffication:	1 🖾 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	M 1 Yes 2 No												
Attended by the by the by the	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home building, etc. (Specify)		cation (Street and Number or Rurel Route Number, y or Town, Stete)											
Division c tal or Attending P is after death. al Director: Atter led in by the funers Certification:	Salaring, old. (option)													
Divisio To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completaly filled in by the tr	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle	edge, death occurred et the time, date end plece, and due n end/or investigation, in my opinion, death occurred at th	to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)											
ithin ithe omple	29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)											
F 3 F 8	NV. ()	11M D18705	FEBRUARY 20, 2006											
,	30. Neme end eddress of person who completed cause of death (Item 2:	3e) (Type Print)												
1	310 g g	ETON AVE., EMMITSBURG, MD.	21727											
State	31. Dete filed (Month, Day, Year) 2. Registrar's Signatur		4-141											
Registrar	FEB 2 4 2006	foods												

			For State Registrar	State of Maryland		irtment of He tificate of D			ene g. No. 006	05689
	Bluedal		Decedent's Name (First, Middle, Las	t)				2. Date of Death		3. Time of Death
	Physici /Medic				atson			02 -	18-200	6 4.06 AM
)	Examin	er	4a. Facility Name (If not institution, give 502 W. Industrial E			Cumberla	Location of Death and		4c. County of D Allegany	
	Funeral		5. Social Security Number 6. So	ox 7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9.1	Birthplace (State or Foreign
	Director		215-26-9424 1 Usual Residence of Decedent	□ ^{M 2} [X ^F 76	Yrs.	Working Days	Tiours IVIII.	Feb 13;	1930	CoulVID
	/land		10a. State 10b. County	10c. City	, Town or Lo					10d. Inside City Limits
	e Man	ctor	MD Allegar	ıy	Cumb	erland				1 ∑Yes 2 □ No
	vith th	Dire	10e. Street and Number			10f. Zip Code	04500	10	og. Citizen of What USA	Country?
	leath v	Funeral Director	502 W. Industrial (3IVQ. 12. Was Decedent Ever in U.S	S. 13. V		21502 spanic Origin? (Sp	ecify Yes or No-		merican Indian,
Maryland 21215-0036	swihin 72 hours after death with the Maryland jene. rthen "natural", or flams 23a or 28s-f ehow the Madical Exammer must be multified at	þ	1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	-	Vas Decedent of His Yes, specify Cubar □ Yes 2 No	n, Mexican, Puèrto Specify:	Rican, etc.)	Specify: W	hite, etc.
5-0		letec	15. Decedent's Ed (Specify only highest gra		(Give	ent's Usual Occupa kind of work done d OO NOT use retired	uring most of work	ung	16b. Kind of Busine	ss/Industry
712	e filed within al Hygiene. I other then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Decorator		E	Bakery	
nd	Hyg othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam		_	
<u>ya</u>	should be nd Mental marked umatic ev	၉	William Henry G		10h Mailie	- Add (St		, , , , ,	Green	Zin Codo)
	od 2 lith a 27 is r trat		Frank Watson Jr.	son	437	g Address (Street a South Stre	eet	Cumb	erland	MD 21502
Baltimore,	00		20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	metery, cren	sition (Name of natory or other place semetery		2/22/2006	Cumberla	
Balt	permit. Page Department Important: if eny injury o		21. Signature of Funeral Service Lich	see helli	22	Name and Addres Scarpell 108 Virg	i Funeral H inia Avenue	ome, PA e: Cumberl	and, MD 21	502
ı			23a. Part 1. Enter the disease, or companies to the companies of the compa	ications that caused the death one cause on each line.				or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in dealh)	a. CORONARY Due to (or as a consequ	/ AR	TERY I	DISEASE			CHRONIC
	Examiner			bus to (or as a consequent	erice or).	,				
	p ti	Iner	Esqueritially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):					
/	xecute and al-tran	Examiner	that initiated events resulting in death) Last	cDue to (or as a consequ	ence of):					
58760,	tificate be executed ig physicien and as the burial-transit	dical		d						
_	entifica ding pl		IF FEMALE:	23c. If yes, outcome of pregnar	nov.			-		
P.O. Box	the death certif y the ettending sched for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
	The law requires that the death certifies to been signed by the ettending vie hes been signed by the ettending bage 2 should be detached for use a	þ	Part II. Other significant conditions or	ontributing to death but not resu	lting in the ur	nderlying cause give	n in Part I.			e to the causa of death? Probably 4 Unknown
Division of Vital Records,		Completed						24a. Was ar autops perform 1 ☐ Yes 2	prior red? death	aulopsy findings available to completion of cause of ? 'es 2 \sum No
Vita	ector, pa	Be	25. Was case referred to medical examiner?	Hospital:		Othe	ACT	th (Check only one		
ō	Phye	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	t 3 DOA 28c. Injury Work	4 Unursing Ho	ome 5 Reside 28d. Describe ho	nce 6 Other (5 w injury occurred	ipecify)
ion	or Attending Physician: Ifter death. Sirector: After this certific in by the funeral director,	atlo	1 Natural 5 Pending investigation		Injury		res 2 □ No			
Divis	after de Directed in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify,	me, farm, stre	eet, factory, office		28f. Location (Sti City or Town	reet and Number of , State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifying Ph (Check only one) Certifying Ph 2 Medical Exam	ysician: To the best of my know liner: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the time restigation, in my op	e, date and place, finion, death occur	and due to the ca red at the time, da	use(s) and manner ite and place, and	r as stated. due to the cause(s)
	With:	Σ	29b. Signature and title of certifier	M.D.		29c. License	number	29	od. Date signed (M	onth, Dey, Year)
			30. Name and address of person who	completed cause of death (Item	23a) (Tune	Print)	107847		721	0 6
_	5		KALPANA DE, M.Z). 912 SETT	IN DR	WE CUN	<i>iberlan</i>	D, MD.	21502	•
	Sta Registr		31. Date filed (Month, Dey, Year) FEB 2 4 20	32 Registrar's Signal	ure Sp	ule)				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg, No. [] [] [] [] [] [] [] [] []	90
		1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time	of Death
X.	Physiciar /Medica	1) ANDRES LURENZO WEIGHT Feb. 1 2006 10,	20 Am
	Examine	4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Jocation of Death 4c. County of Death	1195
-		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Settler)	trou Aoreian
	Funeral Director	5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Year) Property of the second of	Genres
		Usuel Residence of Decedent	Olar Islania
	with the Maryland a or 28a-f show Leanchflied at	10a. State 10b. County 15 TRICE 10c. City, Town or Location 10d. Inside	es 2 No
	the M	106. Street end Number 10f. Zip Code 10g. Citizen of Whet Country?	
	h with	600 MARRINGION SI. S.E. 20032 USA	
	ems 23	10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 11. Maritel Status 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
20	s aftar	If Yes, Give 1 □ Yes, 2 Lat No. Specify: Specify: Specify:	-
5-0020	72 hours aftar natural', or fte fical Examine	3 Wildowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry	
215	hin 72	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Fafther's Neme (First, Middle, Last) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 18. Mother's Name (First, Middle, Maider Surname)	a.T
2121	Ad wit	None None None-Instant None-Inst	2.771
Maryland			1ipp
7	thould od Mar marks matic	19a. Informant's Name/Relationship (Type, Pyfint) // 07/148 19b. Mailing Address (Street and Number or Rural Rougle Number, City, or Town, Stele, Zip Code)	
Z	nd 2 suith an alth an 27 is r trau	SPARKIE K. SANIER GOD SARRINGTON ST. S.E. WASH. OC.	0032
re,	of Hearlitern	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
<u>m</u>	Page nent c ant: if ury or	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Release to too tal PGHC	D_{i}
Baltimore,	Departr Departr Importa any inji	21. Signature of Futheral Service Licensee 22. Name and Address of Facility PGHC	
_	70 E # 9	3001 HOSPITAL DRIVE CHEVERLY, MD 2	0785
		23a. Fatt. Enter the disease, or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, interval E onset an one of the disease on each line. Approximation of the disease or respiratory errest, interval E onset an one of the disease of t	Between
)	Physician /Medical	Immediate Cause (Final	
	Examiner	disease or condition resulting in death) Due to (or es a consequence of):	
	D #		
	be executed ician and burial-transit	Sequentially list conditions, if eny, leading to immediate it ease. Enter Underlying	
68760,			
~	* m at	resulting in death) Lest	
Вох	death certific e ettending p ed for usa as	d	
Э. В	0 0 4	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4	e of death?
P.0	igned by the e	1 □ Yes 2 ☑ No 3 □ Probably 4	Unknown
Division of Vital Records,			y findings
9	been si should	available pric competion of death	or to of cause
Re	The law ata has b page 2 s	24a. Was an autopsy performed? 24b. Were autopsy available principle to completion of death?	.□ No
ita	ician: The certificata rector, pag	25. Was case referred to medical 26. Place of Death (Check only one)	
≥	Fig. F	1 Yes 2 No Pospital: 1 Impatient 2 ER/Outpatient 3 DOA Outlet: 4 Nursing Home 5 Residence 6 Other (Specify)	
u C	D 0 0 0	27. Manner 1 ath 28a. Date of thiury 28b. Time of Injury 1 A sturel 5 Pending investigation 28b. Time of Injury M 28c. Injury at Work? 1 Accident investigation 28c. Injury at Work? 1 Yes 2 No	
isi	Attending ir death.	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route N City or Town, State)	umber,
<u>S</u>	al or safter	27. Manner Teath Adapter S Pending investigation	
		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and due to the cause(s) and manner as steted.	e(s)
	the thin 2, the f	one) and manner steted. 29c. License number 29d. Date signed (Month, Day, Yeer	7)
	7.≱ ₽8	NO 26819 2-1-20	06
		30. Napre end eddress of person who completed cause of death (Item 23a) (Type, Print)	
		and manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 30. Name end eddress of perion who completed cause of death (Item 23a) (Type, Print) 31. Dete filed (Month, Dey, Year) 32. Degistrer's Signature 33. Degistrer's Signature	J
	State	a 31. Dete filed (Month, Dey, Year) 32. registrer's Signature	
	Registra	LEDY O COMO	

				1 - For Stata Registrar	State o	f Marylai		partme <i>ertifica</i>				lental Hy	gien Reg. N	UUb	0	5691
	. 75-	Physici		1. Decedent's Name (First, Middle, La PHILIP R. YAN	*							2. Date of D	D	ay 14, 2000	r .	3. Time of Death
		/Medic Examin		4a. Facility Name (If not institution, giv Upper Chesapeake I				4b. Ci	ty, Town, d Bel		of Death	1 come		c. County of De Harfo	ath	
		Funeral Director		5. Social Security Number 6. S 212–22–8639	Gex ISIM 2□ F	7. Age (In yrs		Month	der 1 Year is Days	If Unde Hours	Min.	8. Date of B (Month, D 5/5/	irth lay, Yea 1928	r) 9. B Ma	Birthplace Country)	e (State or Foreign and
		ow ow		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town o	r Location							10d.	Inside City Limits
		Ra-f sh	Director	PA York			De1ta									1 ☐ Yes 2 ☑ No
Z		death with the Maryland ims 23a or 28a-f show	ai Dire	10e. Street and Number 129 McCall Road	Ē			10f. i	Zip Code 1731	4			10g. C	itizen of What US		?
2015 an	920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exaction and the relified at ODGs.	by Funerail	11. Marital Status ***Times	Armed Fo	2 No		If Yes, s	cedent of I pecify Cub 2X No	an, Mexica	an, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Ar Black, Wi Specify: W	hite, etc.	
06	21215-0036	n 72 ho "natur	Completed	15. Decedent's E (Specify only highest gr	ade completed)		16a. De	ecedent's U. Bive kind of fe. DO NOT	sual Occup work done	oation during mo	st of work	ng	16b.	Kind of Busines	ss/Indus	try
0	212	ed withi ygiene. ner thar	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)		borer						nstruct	cion	
	land	ild be fit lental H ked oth	To Be	17. Father's Name (First, Middle, Last William R. Yanta								e (First, Middle et Mori		en Sumame)		
8	Maryland	d 2 shouth and Mithand Mithand Mithander Traumat	-	19a. Informant's Name/Relationship (Margaret D. Short		c		lailing Addre					ber, City	or Town, State	a, Zip Co	ode)
30/H/C.	Baltimore,	Pages 1 an ent of Heal nt: If item 2 y or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Dopation 5 ☐ Other (Speci	Removal from	20b.	cemetery,	isposition (for crematory of 111e)	r other pla			Date /2006		Location - City		, State
iq	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, F									A 17	7314					
	i k	e H		23a. Parti. Enter the disease, or comshock, or heart failure. List only	polications that	caused the decearch line.	n. Do not	enter the m	ode of dyi	ng, such a	is cardiac o	or respiratory	arrest,		In	pproximate terval Between nset and Death
		Physician /Medical		Infraediate Cause (Final disease or condition resulting in death)	a Due to	(or as a conse	duence of)									
		Examiner	70	Sequentially list conditions,	b. Due to	A JyJT	f () e								-	
	J	ocuted nd transit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C											
44	8760,	certificate be executed confidence by side and transities as the burial-transities.	dical Ex	Tosumy in death) Last	d.	(or as a conse	iquence ot)									
76	9	ertificat ing ph) e as th	Medi	IF FEMALE:	00-16		7.55								-	
#35	O. Box	death	hysician/Me	23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	1 🗆 Live	tcome of pregr birth 2 Per nant at time of lown	tal death	3 Ectopic 5 Other		у				23g. Date of t Month	Da	y Year
9	s, P	es tha gned be de	by P	Part II. Other significant conditions	contributing to c	leath but not re	sulting in th	ne underlyin	g cause gi	ven in Pari	t t.			use contribute		
=	ecord	v requir been si should	leted	- CMiry 21	n c							24a. Wa	Yes		Probabl	y 4 ZUnknown findings available
Phi	α	2 5 0	Compl									aut	opsy formed	prior t death	to compl	etion of cause of
. 1	Vital	Physician: this certific al director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2[] ER/Outp	ationt 302	DOA Ot	her		Check only		6 □Other (S	nacifu)	
7	n of	ding Phys	-	27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Tim Inju	ne of iry	28c. Inju Wo	ry at		28d. Describe			pecity)	
Yar	Division	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined	e 28e. Plac	e of Injury - At ing, etc. (Spec	home, farm	M , street, fact]Yes 2[28f. Location City or To		and Number or ite)	Rural R	oute Number,
	_	e Hospital 24 hours Funeral letely filled	Medical Co	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	miner: On the b											
		To the within To the comp	Me	29b. Signature and title of certifier	M.	- J	m. K	1	29c. Licen	065	45			Date signed (Mo	01	,
_		1		30. Name and address of person who	completed cau	e of death (Ite	em 23a) (Ty	pe, Print)	Saw	ako	De	Pol 4	10	mo	211	014
		Šta Registi		31. Date filed (Month, Day, Year)	06	Registrar's Sign	nature	parti	Supe	NO.	21.		1	mo	J 1 C	1
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FREDERICK 7:40 RUSSELL 2006 -20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 6. Sex Date of Birth (Month, Day, **Funeral** 1**⅓**M 2□ F Months 72 219-30-1565 Director Nov 25 1933 West Virginia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show any Injury or other treumatic event, the Mudical Exam an injury or other treumatic event, the Mudical Exam an injury or other treumatic event, the Mudical Exam and injury or other treumatic event, the Mudical Exam and an injury or other treumatic event, the Mudical Exam and an injury or other treumatic event, the Mudical Exam and an injury or other treumatic event, the Mudical Exam and an injury or other treumatic event, the Mudical Exam and an injury or other treumatic event, the Mudical Exam and an injury or other treumatic event, the Mudical Exam and an injury or other treumatic event. Maryland Calvert St. Leonard 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20685 United States 5960 Long Beach Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

Lateral Yes 2 No figure 19 No Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify.white 1 ☐ Yes 2 ☐ No Specify: à 56-58 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) B.G. and E. purchasing agent 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ruth Davis Russell Zinn ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5960 Long Beach Dr. St. Leonard MD 20685 Helen L. Zinn- wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 9 Southern Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dunkirk Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20676 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events nding physicien and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown þ s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 25 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an s certificate has t lirector, page 2 s autopsy performed? 2 🗆 No Yes or Attending Physicien: Be 25. Was case referred to medicat 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို Inpatient 2 ER/Outpatient 3 DOA andir, redeath. for: After th. redeat dir 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural s after dea. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a To the Funerel L 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3,2006 mo lan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MARYLAND 22 SOUTH GREENE STREET. 10)+1 MARC F. BRAZIE 31. Date filed (Month, Day, Year) 32. Registre's Signature State GLAGUE. Registrar

		-	For Stata Registrar	State of Ma	aryland /		artment			ind M		giene	06	05693
47		_	Decedent's Name (First, Middle,	Last)							2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medic	al		Richard Pay	ne Arbo	ogas	t				Februa	ry 22	, 2006	
	Examin	_	4a. Facility Name (If not institution,					Town, or l aneyt	ocation o	Death			ounty of Dea arroll	th
			Lorien Nursing 5. Social Security Number		e (In yrs. last b	virth day)	If Under		If Under 2	24 Hrs.	8. Date of Birl	h		tholege (State or Foreign
	Funeral Director		234-44-1424	2 F 7		Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)		thplace (State or Foreign buntry) st Virginia
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside City Limits
	Mary -1 sho	to	Mareri and Ca	rroll	:		г	Tanos	town					1 ☐ Yes 2% No
	h the	Director	Maryland Ca 10e. Street and Number				10f. Zip		201111			10g. Citize	n of What Co	ountry?
	th wit		3681 Senft Ro	ad					21	787		Uni	ted S	tates
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Merital Hygiane. Item 27 is marked other than "natural", or Iteme 23s or 28s-f show other traumatic event, Ite Medical Examinations multilied at	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:			Was Deced If Yes, spec		panic Orig , Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		Black, Whit	encan Indian, le, etc. White
21215-0036	2 hou	ted t	15. Decedent	s Education	16		dent's Usua			6		16b. Kind	of Business	
215	within 72 ane. than "nat	Completed	(Specify only highest Elementary/Secondary (0-12)	Grade completed) College (1-4or 5	5+)	life.	kind ol wor DO NOT us	rk done di se retired)	uring most	of workin	ig			
21	ed within /giane. /er than t, the Me	Con	12 Years			Dra	ftsma						el Ind	ustry
Maryland	be filed vital Hygia	Be	17. Father's Name (First, Middle, L	ast)							(First, Middle,	Maiden Su	ımame)	
<u>≯</u>	2 should to and Ment is marked	၉	Richard Y. Ark 19a. Informant's Name/Relationsh		10	ab Mailie	· ·	(Street a		a Pa	yne I Route Numbi	ar City or T	Town State	Zin Code)
Mai	d 2 st th and 7 is n traun		Mrs. Pamela Rus		, , ,						asadena		2112	_
	s 1 and 2 if Health Item 27 i		20a. Method of Disposition	,2111 (5011)	20b. Place	ol Dispo	sition (Nan	ne of			ate		tion - Gity or	Town, State
Baltimore,			1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			-	matory or or		. 1	2/25	/2006	Midd	ile Ri	ver, MD
ij	프린토글 .	1	21. Signature of Funeral Service L		HOLLY	22	Name an	d Addras	of Facility	v				
ä	Depa Impo any I		10000	\bigcirc		Dı	uda-R 7922 '	uck 1 Wise	uner. Ave.	a⊥ H Du	ome of ndalk,	Dunda Mary	aik, i land	21222
1	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a Meta	no. Istatii	o not ent		e of dying	, such as	cardiac o	r respiratory a			Approximate Interval Between Onset and Death
	Examiner			Due to (or as	a consequence	e or).								
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	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence	e of);							_	
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99		B												
.О. Вох	at the death certificat by the attending phy tached for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		⊒Ectopic pr ⊒ Other (sp					23	d. Date of de Month	olivery Day Year
<u>α</u>	uires that n signed b	ρ	Part II. Other significant condition	ns contributing to death b	out not resulting	in the u	nderlying c	ause give	n in Part I.			obacco use Yes 2 🗆		o the cause of death?
of Vital Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed									24a. Was auto perio	psy prmed?	24b. Were a prior to death? 1 ☐ Ye	utopsy findings available completion of cause of
ita		Bec	25. Was case relerred to medical						26. Place	of Death	(Check only			
<u>†</u>	8 .g = 5	To E	examiner? 1 ☐ Yes 2 ☐ Ño		ent 2 ER/0	Outpatier	nt 3□ DC	Othe Othe	4 2 Nu	irsing Hor	ne 5□Resi	dence 6[☐Other (Spe	ecity)
Ē	gr en		27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry 28b y Year)	. Time o Injury		8c. Injury Work			28d. Describe	how injury	occurred	
Sio	Attending r death. ector: After by the fune	catl	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	at ha	445	In one on	M		/es 2 □		281 Location /	Stroot and	Number or E	Jural Route Number,
Division		Certification;	4 ☐ Homicide determi	28e. Place of Inj building, et	tc. (Specify)	iaim, su	reet, ractory	y, omce			City or To		VOIIIDO I OI I	and in total and an
	Hospil 24 hour Funer stely fills	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical 8	g Physician: To the best Examiner: On the basis o and manner st	of examination a	lge, deat and/or in	th occurred evestigation	at the tim	e, date an inion, dea	nd place, a	and due to the ed at the time,	cause(s) a date and p	nd manner a lace, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	MD			290	. License	number 252e	235	-	29d. Date	signed (Mon	nth, Day, Year)
5	1		30 Name and address of person of SINU CHACK	who completed cause of c	death (Item 23a	a) (Type,	Print)		Weg	tain	15ten	MS) 2	1157
	Sta		31. Date liled (Month, Day, Year)	E.	rar's Signature		/							
	Regist	rar	FEB 2 7	2006	was St	6	medi	7						

AEM 06-01311 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,pen/ff, 9853,3/8/06 TT beartment of Health and Mental Hygiene, On Comparison of the Comparison of the Copies Are Legible. David Acree 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2006 DAVID February ACREE /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Baltimore City
If Under 1 Year | If Under 24 Hrs.
Months Days | Hours | Min. n/a 8. Date of Birth (Month, Day, Ye APRIL 29 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1X M 2 ☐ F Yrs. 1955 MARYLAND 50 Director 219-66-5219 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count 28a-f show the Medical Examiner must be notified at Y☐ Yes 2 ☐ No BALTIMORE MARYLAND N/A Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 23a U.S.A. 5358 SINCLAIR LANE APT G 21206 deeth Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK þ 3X Widowed 4 □ Divorced "naturs!" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) JANITORIAL FLOOR TECH 12th grade other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of FLORABELLE SMITH NICHOLAS ACREE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21206 t of Health 5358 Sinclair Lane, Apt G, Baltimore, Maryland Paula Artis/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 02-25-06 BALTIMORE, MARYLAND KING MEMORIAL PARK 21. Signature of Funeral Service Lin 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE callen 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Atherosclerotic cardiovascular disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) nding physicien and use as the burial-transit Attending Physician: The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atten for u 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the sahould be detached Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4 X Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 2 No has nis certificete l' director, page 12 Yes 2 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 □ No Hospital: Other: 2 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification; Division 5 Pendina death. 1 ☐ Yes 2 ☐ No investigation М i Diractor: / 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours as To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

lasha

31. Date filed (Month, Day, Year)

asha

bera 32 Registrar's Signature

Jess

2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

February 22,

29c. License number

OCI/IE

		·	For State Registrar	State of I	Marylan	•		nt of H				Reg. No.	UUD	05698	j
	Physicia	an	Decedent's Name (First, Middle,								2. Date of De. Month	Day			
	/Medic	al	4a. Facility Name (If not institution,	give street and numb	O AMS		4b Cit	v Town or	Location of		FEBURA		23, 200 E		
	Examin	er	Baltimore 4	1ASHINGTON	Cen	LIC41		واحم	7	-nie) ,		TNNE	./1	./
	Funeral Director		5. Social Security Number 217–20–1202	6. Sex 7. 1 □ M 2 🖾 F	Age (In yrs. 79	last birthday) Yrs.		er 1 Year	If Under 2	4 Hrs. 8 Min.	Date of Bird Month, Da June	h 2 ^{Year)}	9. Bi	rthplace (State or Forei country) aryland	ign
	D P		Usuef Residence of Decedenf 10a. Stafe 10b. County		10c Cit	y, Town or Lo	cation						· · · · · · · · · · · · · · · · · · ·	10d. fnside City Limi	ite
	Aaryla f sho	٥		imore	100. 01	y, rown or Lo	Canon	Du	ndalk					1 Yes 2X	
	r 28a-	Director	10e. Street and Number				10f. Z	ip Code				10g. Citi	izen of What C	Country?	
	th with		858	8 Mildred A	Avenue				2	1222			USA		
	filed within 72 hours after deeth with the Maryland Hydione. Ither than "natural", or iteme 23a or 28a-f show ant, Ita Mwilcel Examinan intak be notified.	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	S. 13.	Was Dec	edent of His	spanic Origi n, Mexican,	in? (Spec Puerto R	rfy Yes or No ican, etc.)	-	14. Race - Am Black, Wh		
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☒ Divorced	od 1 Tes 2 If Yes, Give Year or Date			1 🗆 Yes	2 ⊠ No	Specify:				Specify:	White	
21215-0036	72 hours "natural",	ted	15. Decedent'	s Education		16a. Dece	dent's Us	sual Occupa	tion	of modern		16b. Ki	ind of Busines	s/industry	
21	ithin 7 96.	Completed	(Specify only highest Elementary/Secondary (0-12)	Coflege (1-4	or 5+)	life.	DO NOT	use retired) emaker		or working	,		Own Hor	ne	
121	iled w Hygier ther th	Co	8 17. Father's Name (First, Middle, L	0			поше			's Nama /	First, Middle,				
and	at a b	To Be	17. Father 3 Haille (1 113t, 1110010, L	John	Lynch						alisbu		Sumame,		
Maryland	s 1 and 2 should be filed within 7 Heelth and Mental Hygiene. Itam 27 is marked other than "r other traumatic avant, Ital Mail	۲	19a. Informant's Name/Refationsh										r Town, State,	_ '	_
Σ.	2 = 20 -	٠,	Gordon W. Ad	ams (Son)					re Kd.		ndalk,				
ore	00		20a. Method of Disposition 1 □ Burial 2 🖾 Cremation	3 □Removal from Sta		Place of Dispo	natory of	other place	Tnc	Da			cation - City o	r Town, State , Maryland	
Baltimore,	permit. Pages Depertment of Important: If It any injury or o		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		E Eck				1						_
Ra	Dep impo		1/2	KCVIII	L DC		IcCu. 3204	lly-Po Mount	lynia ain R	ık Fu	neral Pasade	Home na.	P. A	21122	
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	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):					NEAR				
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o,	cate be executed physicien and the burial-transit	EX	resulting in death) Last	Due to (or	as a conseq	uence of):									
	physic physic the b	dlcai	,	d					_						
ROX	death certifii e attending i id for use as	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			-						23d. Date of de	elivery	
ň	0 0	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		h 2 ∏ Feta it at time of d		JEctopic ∃Other (pregnancy specify)					Month	Day Year	
0.	that the de ed by the a detached	Phy	9 ☐ Unknown Part II. Other significant condition			ulbina ia tha			- in Death		220 Did t	obanes :	usa saatabuta	to the cause of death?	
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Ö	w requir been si should	lete		-						_	24a. Was	an	24b. Were a	autopsy findings availat	ble
Vital Records,	The lav	Completed									autor perfo	rmed? 2 No	death?	autopsy findings availate completion of cause of s 20 No	əf
		BeC	25. Was case referred to medical examiner?							of Death	Check only			20110	_
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u O	ding I	tion	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig		Day Year)	28b. Time o Injury	r M	28c. fnjury Work	at ? ∕es 2 ⊡N	1	3d. Describe	now injui	ry occurred		
Division of	or Attancter death fractor: n by the	Ifica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of	Injury - At h	ome, farm, str					3f. Location (Street an	d Number or I	Rural Route Number,	
ā	ospital or A hours etter unaral Dira ly filled in b	Certification;	4 Horniciae	building	, efc. (Specit						City or To				
	I 4 IT 0	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the be examiner: On the basi and manne	is of examina	wledge, deat tion and/or in	h occurre vestigati	ed at the tim on, in my op	e, date and pinion, death	l place, ar h occurred	nd due to the d at the time,	cause(s) date and	and manner a diplace, and di	as stated. ue to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier				2	9c. License	number			29d. Da	te signed (Moi	nth, Day, Year)	
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	6		30. Name and address of person v									.,	1 12-	4 23, 2006 MS	
	Sta	to	BALTMOILE (a 31. Date filed (Month, Day, Year)	ASITING TO	pistřar's Signa	16Dici	tc	Cori	-1		nen	Bul	LNIG	140	
	Registr		FEB 2				1000	San Property							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item# 23a, 27, 28a-f, pen/e, 853, 3/27/06 IT State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 23, 2006 **Physician** 6:39 PM **JOSEPH** AMATO /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Glen Burnie Baltimore Washington Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | August 30,1955 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**M**M 2□F Maryland 214-72-2159 50 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland Anne Arundel Glen Burnie Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Queen Anne Road 21060 U.S.A. Ітете 23в death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married ō Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: δ 3 Widowed 4 Divorced "neturel" Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Cook Resturant it of Health and Mental Hyg If Item 27 le marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Louis Amato Gertrude Schmidt ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Queen Anne Road, Glen Burnie, Maryland 21060 Dorothy M Amato (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If eny injury or once. Bayview Crematory 02-28-06 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) McCully-Polyniak Funeral Home P.A.
3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Amitriptyline intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has t autopsy performed? death? certificate 2 No 1 Yes 2 🗆 No within 24 hours efter death.

To the Funaral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1√2 Yes 2 □ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 📆 No Fnd 2/23/2006 2 Accident Fnd 6:10 p unk 6 X Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5 Queen Anne Rd. Anne Arundel, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide Found: Residence To the Hospital within 24 hours e To the Funaral C 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME February 24, 2006 show M. 30. Name and address of person who completed cause 🦸 eath (Item 3a) (Type, Print) HEMORE Miken 111 PEnn Street, Baltimore, maryland 21201 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

FEB 2 7 2006



State of Maryland / Department of Health and Mental Hygiene

						,		Certificate				R	eg. No. 0	36	05697
	Di		1. Decedent's Name (First,	Middle, Li	est)		-					2. Dete of Deel		Year	3. Time of Death
· N	Physici /Medio		Pauline Ad	ams								Februar			1:20 PM
	Examin		4a Fecility Neme (If not inst	itution, gi	ve street end numb	er)				4b. City, To	wn, or Lo	ocation of Death		ty of Death	
			Julia Mano			ne				Hage				ashin	gton
	Funeral		5. Social Security Number		Sex 7. 1 □ M 2 汉 F	Age (In yrs.		Months	1 Year Days	If Under Hours	Min.	(Month, Dey	Year)	9. Birth	place (State or Foreign intry)
	Director		198-34-6393			60	Yı	s.				Mar 13,	1945	Penn	sylvania
	pue *		Usuel Residence of Deceder 10a. State 10b. Co			10c. Cit	y, Town	or Location							10d. Inside City Limits
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	3a or	Funeral Director	11 S. Walnu	t St	reet #114	1				21740	1		US		,
	death	Jera	11. Marital Status		12. Was Decede	ent Ever in U	S.	13. Was Deced	lent of I-			ecify Yes or No- Rican, etc.)			ican Indian,
0	if the		1 ☑ Never Married 2□	Married	Armed Force	₩ No	-					Rican, etc.)	Bia	ack, White	, etc.
8	ers a	þ	3 Widowed 4 □ Div	orced	If Yes, Give Year or Date			1□ Yes 2	2 X No	Specity:			Speci	ity: wh:	ite
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Baltimore, Maryland 21215-0020	parmit. Peges 1 and 2 should be filed within 72 hours after death with the Marylen Dapartment of Haalth end Mantel Hygiana. Important: if Item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema	tion 3 [Removal from Sta		emetery,	isposition (Nan crematory or o	ther plac	сө)	1	Date	20c. Location	- City or I	own, State
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н	E AGITITIO .	-	resulting in death)			Due to (o	rasaco	nsequence of):	(f L	,				
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<u> </u>	ysicia s car direct	To B	examiner? 1 ☐ Yes 2 ☐ No		Hospital:	atient 2	ER/Outp	atient 3 DO	A Oth			me 5□Reside		ther (Spec	ifv)
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Division of Vital Records,	er de er de by th	율	3 ☐ Suicide 6 ☐ Co	ould not be termined	286. Place of	Injury - At ho		, street, factory	, office			28f. Location (St City or Town		ber or Rui	ral Route Number,
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	To the Hospital or Attanding Physician: The la within 24 hours after death. To the Funeral Director: After this cartificale has complataly filled in by the funeral director, paga?	edical	29a. Certifier 1 Cer (Check only 2 Med	tifying Ph	yaiclan: To the be	st of my know	viedge, o	eath occurred a	in my o	ne, date an	d place, a	and due to the ca	ause(s) and m	anner as	stated.
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			30. Name end eddress of pe	rson who	completed cause of	of death (Item			112	-6	000	al ct		2.1	740
2			31. Date filed (Month, Day,)	'earl	30 000	strar's Signa	W C			1A-0	qex;	stown	W) \ \ \	1-[0
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 26, 2006 Physician 2:09 a M Italo N. Broccolino /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Towson Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Min. March Day Year) 5. Social Security Number 219-03-5616 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Months Days 11XM 2□F Mary land 91 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b Count r then "natural", or items 23s or 28s-f show the Medical Examinat the notified at Md. Baltimore Lutherville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1201 Dublin Ct. 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Jeweler Jewelry Store nd 2 should be filed with and Mental Hygier 27 is marked other the treumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Heaith and Mental importent: If Itam 27 is marked 1 any intry or other treumatic eventaging. Joseph Broccolino Adeline Naddeo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Liliana Broccolino/ Wife 1201 Dublin Ct. Lutherville, Md. 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 COther (Specify) Entombment Dulaney Valley Mem. Timonium, Md 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funetal Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Syndrome with multi-orgina Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) anding physician and use as the burial-translt Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 A No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral is 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide or A 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number February 26, 2006 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 M. Charles St. Balto. Md 21208 G BMC 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Decelinos

			1 - For State Registrar	State of Maryla		artment of H			ene 2006	05699
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-11	Examin	er	4a. Fecility Name (If not institution, give s 1004 Breezewich			4b. City, Town, or Towson	Location of Dea	th	4c. County of Deat	
	Funeral	* . * .	5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year	If Under 24 Hr		9. Birt	hplace (State or Foreign
1	Director		213-20-2971	M 2X F 81	Yrs.	Months Days	Hours Min	Sept. 12	(1924 ^{cq}	Maryland
	pu .		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	ocation				10d. Inside City Limits
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	the N	rect	10e. Street and Number	,		10f. Zip Code		10	g. Citizen of What Co	unity?
	3a or	by Funeral Director	1004 Breezewick	Rd.		2128	6		US	·
	deat	ner		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		Specify Yes or No-	14. Race - Ame Black, White	rican Indian,
36	or ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	i	1 □ Yes 2 Ϊ No	Specify:	nto riloan, otc.)		nite
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yla	Ment Ment arked	To	John Gill Buck				Nelli			
, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Menial Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28e-f ehow apprintury or other traumatic event, the Maritial Examination at a page.		19a. Informant's Name/Relationship (Ty). Mr. F.Joseph Brady						City or Town, State, 2 Md. 21286	
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Baltimore,	permit Depert Import eny in		21. Signature of Funeral Service License	e de la companya dela companya dela companya dela companya de la companya de la companya de la companya dela companya de la companya de la companya de la companya dela comp	22	Ruck To 1050 Yo	wsfanityfu <u>r</u> rk Rd.	neral Home Towson, Md	Inc. 21204	
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8760, —	rate be executed physicien end the burial-transit	ical Examiner	that initiated events resulting in death) Last	Due to (or as a cons	equence of);					
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Sic	death death stor: /	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home farm etc		fes 2 □ No	28f Location (Str	eet and Number or Ru	um I Pauta Numbas
Ď	25.40	Certification:	4 Homicide determined	building, etc. (Spe	cify)	eet, laciory, onlos		City or Town,		rai nobie Nulliber,
	To the Hospital or Attending Physician: The I within 24 hours elie death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medicai C	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my k	nowledge, death	n occurred at the tim vestigation, in my op	e, date and place pinion, death occ	e, and due to the cau curred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	o the	Me	29b. Signalure and title of certifier	and manner stated.		29c. License	number	29	d. Date signed (Monti	h, Dey, Year)
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	5		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type,	Print) ALIP 2	14 Til	4 m lum	d. Date signed (Monti 2-27- (MD 2104	1 3.
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			1- For State of Maryla Registrar Amend Item #28b Per ME	•			ental Hygier	2 U U D	05700
	Physici		Decedent's Name (First, Middle, Last) Marv D	Burch				21, 2006	3. Time of Death 12:27 P M
1	/Medic Examin		4a. Facility Name (If not institution, give street and number)	Dui Cii	4b. City, Town, or	Location of Death		4c. County of Death	
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	Funeral Director		1□M 2ME	rs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea Aug. 14,	ar) Cou	place (State or Foreign intry) ryland
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	28a-f	Directo	Maryland Baltimore	Timoni	UM 10f. Zip Code		10n	Citizen of What Cou	
	3a or		765 Leister Drive		21093			U.S.A.	.,.
	deeth	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-	14. Race - Amer	
39	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic avant, its Medical Examinational Le notified at	ρ	1 Never Married 2 Married 1 Yes, Give 1 Year or Dates:		1 □ Yes 2 □X No	Specify:	nican, etc.)	Specify:	hite
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2121	ithin 7	npie	Elementary/Secondary (0-12) College (1-4or 5+)	iife.	DO NOT use retired;)	, ing		
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Maryland	should Ind Meni	70	William K. Fuller 19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	Edna and Number or Rura	Zimmi Il Route Number, Cit		p Code)
	and 2 sealth ar n 27 is		Francis T. Burch, Jr. Son	4	Leister D		onium, Ma	50.901	1093
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Balt	permit. Peges Department of Important: If it any injury or once.		21. Signature of Funeral Sarvice Licensee	22	2. Name and Addres	s ol Facility Ru		Funeral	Home, Inc. 21204
			23a. Part1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		UTPLE	FRACTUR		,	Neeks
	Examiner		Due to (or as a con				10	AL EXAMINER	
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_	certifi nding use as	ian/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome ol pre					23d. Date of deliv	/erv
O. Box	The law requires that the death certified hes been signed by the attending age 2 should be detached for use a	Physiciar	in the past 12 months? 1 Yes 20 No 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
р.0	that the by detact	y Ph	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
g	quires n sign	ed by					1 ☐ Yes	2 No 3 Pro	babiy 4 Unknown
ပ္ပ	aw require as been si 2 should t	piete					24a. Was an	24b. Were aut	opsy findings available
Ĭ		Completed					autopsy performed	2 death?	ompletion of cause of 2 □ No
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Division of Vital Records,	Physi this c	٩	1 No Hospital: 1 Inpatient	2 ER/Outpatier		4 Nursing Ho	me 5 Residence		mnospico
Ę.	ding h. After funer	ion	27. Manner of Death 1 □ Natural 5 □ Pending 28a. Date of Injury (Month, Day Year Flywwy 8	28b. Time of Injury	JNK 28c. Injury	rat ⟨? Yes 2 ZNo	28d. Describe how in	•	•
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2	al or A	Certification:	4 Homicide building, etc. (Sp. Homz (Ac	ecify)		1	City or Town, Si 615 Chestn	tate)	
	To the Hospital or Attent within 24 hours effer deatl To the Funeral Director: completely filled in by the		29a. Certifier (Sertifying Physician: To the best of my	knowledge, deatl	h occurred at the tim	ne, date and place,	and due to the cause	e(s) and manner as	stated.
	the H nin 24 the Fi	ledical	one) and manner stated.	mation and/or in					
	No Too	Σ	29b. Signature and title of certifier		29c. License			Date signed (Month	- '
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	15		30. Name and address of person who completed cause of death (N Cue	vies St	DAMMO	Fellow z	1204	
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BURCH, MARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1tem 21 per dyr 9852 2-27-06 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Rag No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) BRIT Physician 2006 26 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SILKY 5 MONIGOMERY lauNe If Under 24 Hrs. 9. Birthplace (State or Foreign Country) If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day **Funeral** Months Days Hours Min. 1 ☐ M 2 X F Yrs. 60 SOLVY Carolina Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or 28e-f ahow If Item 27 is marked other than "natural", or Items 23a or 28e-f abov or other traumatic avent, the Modical Examinar must be multied at 1 Yes 2 □ No MON YING Funeral Director 90MCYY of, Zip Code 10g. Citizen of What Country? 10e. Street and Number U,SA. 2090 Wa permit. Pages 1 and 2 should be filled within 72 hours after deat Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural" or incompany or other traumatic avera. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No It Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Black Specify: ģ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) JOY ? puter Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ONN GREN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of rict 20a. Method of Disposition

N Burial 2 □ Cremation or Town State Zo Do 2 other place) Burial 2 Cremation
Donation 5 Other (Specify) 3 Removal from State GleNWood Cem 06 11425 Mg AVR N.E. 21. Signature of Funeral Service Litohn F Bolden per dvr. Name and Address of Facility 80 Reliable Funeral Wosh. DC. 20002 Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION **Physician** /Medical Examiner HUP FILEN

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed been signed by the attending physicien and should be detached for use es the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □Unknown 2 No 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed2 Yes 2 No 2000 1 Yes To the Hospitel or Attending Physicien: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Assidence 6 Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA After this 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funerel Direct completely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dev. Year, 29b. Signature and title of certifier WW. 30. Name and indiress of person who completed cause of death (Item 23a) (Type, Print) Conveticut Kensington, Md. Epsiein 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 Registrar

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ding F	funer	tion	27. Manner of Teath 1 Natural 5 Pendir 2 Accident investi	ig	28a. Date of Inj (Month, Di	ay Year)	28b. Time Injury		28c. Injur Wor	ryat rk? ∣Yes 2.⊟N		sa. Describe	a now inji	ury occurred			
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DIV.	e E	Certification;	4 Homicide	illeu	building, e	itc."(Specii	y)					City or T	own, Sta	te)			
DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific.	ly fille		29a. Certifier 1 Certifyii	ng Physici	an: To the bes	t of my kno	wledge, dea	ath occurre	ed at the time	me, date and	d place, ar	nd due to th	e cause(s) and mann	er as s	tated.	(c)
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다 를	00	2	29b. Signature and title of certifie	mal	Dn	A.	(A)	2		e number	0	2		ate signed (A			06
	/		JAMES -			1-	- 00 : =		0	176	4 4 5		1-	eb 2		10	
	b		30. Name and address of person SHAGNES +CA	OSPI.	TAL,	geath (Iter	1 23a) (Type	a, Print)	WE.	RA	MITH	MOR	(171) F	MA	, ,	2122	Q
	Sta	te	31. Date filed (Month, Day, Year)		20 Deniet	unda Cian				4			1	1-91		- 1)_^
Re	gistr	ar	EER 2 7	2006	Harris no	Fred A	the A	ande	, 				_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 11 per fh 9852 2-27-06 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** EATHA BERENHOLTZ 20:15 M E614084 22 2006 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 105 oi lau Johns N/A HOPKINS If Under 1 Year II Under 24 Hrs. 8 Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age@In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 213-54-3789 Director 57 10/08/1948 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location Itams 23s or 28s-f show 10d. Inside City Limits other than "netural", or Itams 23s or 28s-f shovent, the Medical Examinational by mailified at MD BALTIMORE OWINGS MILLS Director 1 ☐ Yes 2 🖾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 STREAM VALLEY GARTH 21117 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. WHITE 1 ☐ Yes 2 X No If Yes, Give → Never Married 2 Married 1 Yes 2 No þ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental tem 27 is marked o E CARTER FREDERICK MEAK CONNIE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is JERRY BERENHOLTZ / HUSBAND 3 STREAM VALLEY GARTH - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/24/2006 BETH TFILOH CONG. WOODLAWN, MD permit. 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumorua /Medical resulting in death) Due to (or as a consequence of): **Examiner** Em Golins LMONary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner ponatrenia burial-transit The law requires that the death certificate be executed lays and resulting in death) Last Due to (br as a consequence of): attending physician Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy jo Month Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an certificate has lirector, page 2 s autopsy performed? 1 Tyes 2×No Hospital or Attanding Physician: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 [X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury investigation 1 Yes 2 No 2 Accident within 24 hours after deatl To the Funeral Diractor: 3 🖺 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pellij 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) -000

Registrar

State

31. Date liled (Month, Day, Year)

0

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

North

32. Registrar's Signature

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2006

## PACE CAMPAIN CAMPAI				1 - State Registrar Cert	rtment of Health and Mental Hy tificate of Death	giene Reg. No. 006 05705
Second Security Number 1.5 and a Security Number 1.5		/Media	cal.	4a. Facility Name (If not institution, give street and number)	Month FEBRUA 4b. City, Town, or Location of Death	Day Year 5:04 P M 4c. County of Death
TO THE PROPERTY OF THE PROPERT		Director		5. Social Security Number 224-30-0826 6. Sex 1 M 2XI F 81 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Bir Months Days Hours Min. (Month, Da	th 9. Birthplace (State or Foreign Country) MARYLAND
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234 Mail officer the disease, or complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, inches fightine. List only one cause on each line. 235 Mail officer the disease, or complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, inches fightine. List only one cause on each line. 236 Mail officer the disease, or complications that caused the death of Death of Note and Death		ed within 72 h /giene. ier than "natu	Complete	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BI	ind of work done during most of working O NOT use retired)	
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234 four effect he disease, or complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, immediate Jacussy (Final Indian). 256 Four four as a consequence of): 257 Due to (or as a consequence of): 258 Due to (or as a consequence of): 259 Due to (or as a consequence of): 259 Due to (or as a consequence of): 250 Was decedent pregnant; that indiand events in the four of pregnancy indiand events in the four indiand		l and 2 sho Health and I Im 27 is me		19a. Informant's Name/Relationship (<i>Type, Print</i>) GREAT SHAUNTIA S. LINDSAY/ GRAND 718	BEAVERBOOK RD., BAL	TIMORE, MD 21212
234 Mail officer the disease, or complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, inches fightine. List only one cause on each line. 235 Mail officer the disease, or complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, inches fightine. List only one cause on each line. 236 Mail officer the disease, or complications that caused the death of Death of Note and Death	altimore	rmit. Pages 1 partment of H portant: If its y injury or ot		1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) METRO CF	REMATORY 2/27/06	CATONSVILLE, MD
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) MAW NAIN4 00, ND 30. Name and address of per ni who completed cause of death (Item 23a) (Type, Print) ACOD SAMARITAN HOSPITAL, BACTIMORE, MD.	ai Reco				perfo	prior to completion of cause of death?
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) MAW NAIN4 00, ND 30. Name and address of per ni who completed cause of death (Item 23a) (Type, Print) ACOD SAMARITAN HOSPITAL, BACTIMORE, MD.	ion of Vit	anding Physiciar ath. or: After this certif ne funeral directo	on: To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 1 Matural 5 Pending	3 DOA Other: 4 Nursing Home 5 Residence Residence Advanced Nursing Home 5 Residence Re	dence 6 Other (Specify)
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			1. Decedent's Name (First, Middle, Last)	0				2. Date of De Month	ath Day		3. Time of De	ath
	Physici /Medic		ELEANOR MA	RIE CALLE	NOE	R		02		2006 Ö	750	M
	Examin		4a. Facility Name (If not institution, give si	treet and number)	2	4b. City, Town, or	Location of De	ath	4c. County			
		ш	House of Jubilee 227	8 BALDWIN MILL	Rd	FAUS	TOIN			ford		
	Funeral Director		218-03-9807	7. Age (In yrs. last 92	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	8. Date of Bir (Month, Da Jan. 2	th Year) 1914	9. Birthplace Country) Mary La	e (State or F and	oreign
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	cation	w .			10d.	Inside City I	Limits
	haryl sho	5	2.1.1								1 🗌 Yes 2	
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	eath rs 23	by Funerai Director	5708 Kenwood Avent	2. Was Decedent Ever in U.S.	13 V			(Specify Yes or No		e - American	Indian	
	ter d	Ë	1 Never Married 2 Married	Armed Forces? 1 □ Yes 2 ☑ No	lf.	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Pue	erto Rican, etc.)	Blac	k, White, etc.		
38	irs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2☑ No	Specify:		Specify	whit	te	
ŏ	be filed within 72 hours after death with the Maryland hat Hygiene. Id other than "naturel", or Hems 23e or 28e-1 show event, the Medical Evanta wir must be trofffed at	pa	15. Decedent's Educ	ation 16	6a. Deced	lent's Usual Occupa	ition		16b. Kind of Bu	siness/Indust	try	
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Maryland 21215-0036	permit. Pages 1 and 2 should be f Department of Heath and Mental H Important: If Item 27 Is marked ot any injury or other traumatic even once.	-	19a. Informant's Name/Relationship (Typ	e, Print) 1		g Address (Street a				State, Zip Co	de)	
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Baltimore,	of He item		20a. Method of Disposition	20b. Place	of Dispos	sition (Name of natory or other place	9)	Date	20c. Location -	City or Town,	, State	
Ĕ	Page nent c		1 ☐Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)			Nat'1 Ce		22/06	Baltimo:	re, Md		
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	34"		23a Fart1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. D	o not ente	or the mode of dying	g, such as card	ac or respiratory a	rrest,	Ap	proximate terval Betwee	en
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8760,	cate be executed physician and s the burial-transit	lical	d.					· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·			
9	death certifica e attending ph id for use as t	Med	IF FEMALE:									
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	e des	Physician/M	1 ☐ Yes 2 IX No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown	5 🗆	Other (specify)					, , , ,	
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-t	Attending Physicien: r death. ector: After this certific. by the funeral director.	To	1 162 5 5 10		Outpatien		4 🗆 Muising	Home 5 Resi		er (Specily)	LIU	ING
U C	After uner	lon	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	b. Time of Injury	28c. Injury Work		28d. Describe	how injury occurr	ea De		
Sic	death death tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	CO- Diese of Injury. At home			res 2 □ No	29f Logation /	Street and Numb	or or Pural Po	auto Alumba	
Division of	or Al	ertification:	4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, iaimi, stre	set, factory, office		City or To		er or noral no	oute wanter	
ч	Hospitel	O	29a, Certifier 1X Certifying Phys	ician: To the best of my knowled	dae death	occurred at the time	o data and pla	co and due to the	cauco(c) and ma	nnot as stato	d	
	To the Hospitel or Attending F within 24 hours atter death. To the Funerel Director: Atter completely filled in by the funer	edical	(Check only one)	er: On the basis of examination and manner stated.	and/or inv	estigation, in my of	oinion, death oc	curred at the time,	date and place,	and due to the	e cause(s)	
	To the within 7 to the Comple	Med	29b. Signalure and title of certifier	and the standard		29c. License	number		29d. Date signed	(Month, Day	, Year)	
)	F ≥ F ŏ		11/1-1 - X PISC			7 =	31295	-	11	11		
,	-7		30. Name and address of person who cor	moleted cause of death (Item 22	a) (Type	Print) =	1275		- / -	/ -		
1	, ,		(1) 1/ 1/	D. 5601 LARH	RAL	EN BLUD	, P.O.B	Ste 2	08A. B	ALTO. 1	MD 21	239
	Sta	te	31 Date filed (Month Day Year)	pholeted cause of death (Item 23 D 560 L 02 H	Ann	ek 1	,	/				-
	Registr		FEB 2 7 2006	the state of	STATE OF THE PARTY	- Co						

			Registrar		larvland / Den Ce	artment of H rtificate of L		ntal Hygier	The tent will be a	05707
	Physici	an	Decedent's Name (First, Middle, La	st)			2	Date of Death Month Druary 20	Ray noo Yea	3. Time of Death
	/Medic	cal	Virginia	Estelle		1				
	Examin	ier	4a. Facility Name (If not institution, giv)	4b. City, Town, or		1	4c. County of De	
	Funeral		4115 Holbrook Roa 5. Social Security Number 6. S		ge (In yrs. last birthday)	Randall If Under 1 Year		. Date of Birth	Baltin	irtholace (State or Foreign
١.	Director			1□M 2 X F	85 Yrs.	Months Days		Date of Birth (Month, Day, Yearly 20, 19		Virginia
	show		10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits
	Man,	ភ្	Maryland Baltimo	re	Owings	Mills				1 ☐ Yes 2 🙀 No
	h the	Director	10e. Street and Number			10f. Zip Code	0.10	10g.	Citizen of What	Country?
	23a c		9773 Groffs Mill	Drive		21	117	Unite	d State	s of America
	r dea	Funerai	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Speci n, Mexican, Puerto Ri			nerican Indian,
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X	X '0	1 ☐ Yes 2 ☐ XNo	Specify:		Specify: B	
8	within 72 hours after death with the Maryland one. Itan "heturel", or items 23a or 28a-f show he Mudical Exertiner naval be rudified at	edt	15. Decedent's E	Year or Dates:		dent's Usual Occupa	tion	16b	Kind of Busines	
215	n "ne	plet	(Specify only highest gri	ade completed)	(Give	kind of work done d DO NOT use retired)	uring most of working			,
21215-0036	d with glene ar tha	Completed	12	College (1-4or	Diet	ician		нс	spital	Food Service
힏	is should be filed within 72 hours after death with the Maryla hand Mental Hygiene. In and Mental Hygiene is no starked other than "neturel; or items 23e or 28e f show its marked other than "neturel; or items 23e or 28e f show reumatic event, the Medical Examination of the redifferent of the starked of th	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maid	en Sumame)	
<u>Na</u>	Ment Ment arked	To	Joel Arthur Jone	s			Luetta Pu	ılliam		
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationship (-	nd Number or Rural F			
	of Health of Health litem 27 i		Mrs. Lynne Johns	on (Dau	ghter) 4115		The state of the s	-		
altimore,	Pages 1 nent of H ant: if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	Dat	e 20c.	Location - City	or Town, State
Ε̈́Ε	t. Pa rtmen rtent:	1				ematory I	nc 02/21/	'06 Ba	ltimore	, MD 21229
Ba	permit. Pages Department of importent: if it any injury or once.		21. Signature of Funeral Service Lice	nsee r moc 33	3 87	2. Name and Address 28 Libert	^{s of Facility} Lori y Road, Ra	ing Byers indallsto	Funera wn, Mar	1 Directors 1 yland 21133
	Cate be executed I Medical Examiner I the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (15 - 15 - 19 - 19 - 19 - 19 - 19 - 19 -	Due to (or as	s a consequence of): s a consequence of): s a consequence of):	cunt	e e			Interval Batween Onset and Death
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of o	delivery Day Year
rds, P	w requires that been signed is should be det	by	Part II. Other significant conditions	contributing to death	but not resulting in the u	inderlying cause give	n in Part I.	23e. Did tobacc	_	to the cause of death? Probably 4 Unknown
Vital Records,	n: The law re icate has bee r, page 2 sho	Completed						24a. Was an autopsy performed	prior t death	
/ita	ysicien: is certifica director, I	Be C	25. Was case referred to medical examiner?				26. Place of Death (~		
ō	P F Is	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ury 28b. Time o ay Year) Injury	of 28c. Injury Work 1 7 Y	4 Nuising Home	d. Describe how in		Daughter's Residence
Divi	s after d safter d si Direct	Certifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	njury - At home, farm, st etc. (Specify)	reet, factory, office	28	f. Location (Street City or Town, St		Rural Route Number,
)	the Hospitei or Attending hin 24 hours after death. the Funerai Director: Afte mpletely filled in by the fune	Medical	29a. Certifier Certifying Pl (Check only one) 2 Medicel Example (Check only one)	nysician: To the best miner: On the basis and manner s	t of my knowledge, deal of examination and/or in tated.	h occurred at the tim vestigation, in my op	e, date and place, an inion, death occurred	d due to the cause at the time, date a	o(s) and manner and place, and d	as stated. ue to the cause(s)
	within To th	Σ	29b. Signature and title of certifier			29c. License			Date signed (Mo	1
			> >1 h	7 ~		D.	40854)	2121	12006
			30. Name and address of person who	Riseb	er 3	Print) St.	Paul Plac		Hinory	21207
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 7 2006	32. Regist	trar's Signature	ب				

		1	For State Registrer	State of Maryland /		rtment of Hetificate of L			ene s. 2.006	05708
jų.	Physicia	an	1. Decedent's Name (First, Middle, Last) LOUISE	ANNIE CHEEK				2. Date of Death February		3. Time of Death 2:00 AM
	/Medic Examin		4a. Facility Name (If not institution, give s Genesis Nursing			4b. City, Town, or Brook1	Location of Death yn Park)	4c. County of De	
1	Funeral Director		5. Sociat Security Number 6. Sex 218-34-2149	7. Age (In yrs. last b	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov 29,	9. E 1938 Ma	Birthplace (State or Foreign Country) aryLand
	anyland •how		Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. City, To	wn or Lo		ltimore			10d. tnside City Limits 1 ☑ Yes 2 ☐ No
	with the h	i Director	10e. Street and Number 3700	Seventh Street		10f. Zip Code	212		g. Citizen of What	
36	Jawithin 72 hours after death with the Maryland iene. Then. naturell, or iteme 23e or 28e-f ehow then Madical Examiner was the notified a	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	Vas Decedent of Hi f Yes, specify Cubai I □ Yes 2tv No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black, W	merican Indian, hite, etc. White
Maryland 21215-0036	within 72 hou ene. then "nature re Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	e completed) Coltege (1-4or 5+)	(Give lite. l	dent's Usual Occupa kind of work done d DO NOT use retired, embler	ation furing most of wor)	rking	6b. Kind of Busine Venetian	ss/industry Blind Factory
land 2	be filed Ital Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last)	John Pastorek				ne (First, Middle, N		
	SPEE	-	19a. Informant's Name/Relationship (Ty Mary Lou Baines	(Sister)				ural Route Number. Ltimore, I		_
Baltimore,	Pages 1 and 2 nent of Health a int: If item 27 is iry or other treu		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State Holy	cros	sition (Name of natory or other places Cemete:			20c.Location-City	or Town, State , Maryland
Balti	permit. Page Depertment of Important: If eny injury or once.		21. Signature of Furleral Service Licens	θθ Kevin E Ecke	20	Acculty-P	olyniak tapsco A	Funeral H ve., Balt	ome, P.A	21225-1856
8760, 1	Physician // Medical Examiner and phiairtansit the prival-transit	dicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Meta Star Due to (or as a consequence) d.	ce of):	\cap	g, such as cardia		ist.	Approximate therval Between Onset and Death
O. Box 6	The law requires that the death certificate be executed sie hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de: 4 □ Pregnant at time of death 9 □ Unknown	ath 3[Ectopic pregnancy			23d. Date of Month	delivery Day Year
9	w requires that been signed by should be deta	þ	Part It. Other significant conditions co	ntributing to death but not resultin	g in the u	nderlying cause give	en in Part I.			e to the cause of death? Probably 4 Unknown
of Vital Records,	The law recele hes been page 2 sho	Completed						24a. Was a autops perform	y prior	e autopsy findings available to completion of cause of n? Yes 2 No
Vita	yeician: The is certificete director, pag	Be	25. Was case referred to medical examiner?	Hospital:	/Outpatie	nt 3 DOA Oth	or /	ath <i>(Check</i> on <i>ly</i> on Home 5 ☐ Reside		Canada
ion of	To the Hospitel or Attending Physician: within 24 hours effer death. To the Funerel Director: Atter this certifications of the funeral director, completely filled in by the funeral director,	ation: To	1 Yes 2 No 27. Mannex of Death 1 Natural 5 Pending 2 Accident investigation		b. Time of Injury	f 28c. tnjur Wor			ow injury occurred	эрөснуу
Division	el or Atter s efter dea al Director ad in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, st	reet, factory, office		28f. Location (St City or Town		r Rural Route Number,
	To the Hospitel or Attending Phy within 24 hours effer death. To the Funerel Director: After thi completely filled in by the funeral	Medical ((Check only 2 Medical Exam	vsicien: To the best of my knowle iner: On the basis of examination and manner stated.	dge, deal and/or ir	ivestigation, in my o	pinion, death occ	urred at the time, d	ate and place, and	due to the cause(s)
	To t To t	2	29b. Signature and title obcertifier	7 MD		29c. Licens	5047t		9d. Date signed (M	Ionth, Day, Year)
	10		30. Name and address of person who o	ompleted cause of death (Item 23 10 M / 8 10 9 K 328 Registrar's Signature	Ba) (Type	e High	way, P	asadou	, MD	21122
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 7 201	32. Registrar's Signature		and I				

		1	For State Registrar	State of M	arylan		artment rtificate			ınd Ment		iene	6	05709
1. 18		4.5	Decedent's Name (First, Middle, L	ast)							ate of Deatl	h Day	Year	3. Time of Death
	Physicia /Medic		Evere# MC	oates						F	eb	24	2006	0815 M
	Examin	- 61	4a. Facility Name (If not institution, g	ive street and number)			4b. City,	Town, or	Location of	f Death		4c. County	of Death	
1 5.	# ·	20 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	University of t	Taryland A	18dic	el Center	16112 des	100	If Under 2	مرجهم	- CDiah	1~/	O Binth	-lana (State on Familia
	Funeral			Sex 7. Ag 1 M 2 ☐ F	ge (In yrs. I	ast birthday) Yrs.	If Under Months	Days	Hours	Min /A	ate of Birth Month, Day,	1922	Cou	place (State or Foreign htry) SINIA
1	Director	-	215-12-3559 Usual Residence of Decedent		0.0					Dec	. 04,	1722	1 11 8	511114
	yland yland		10a. State 10b. County		10c. City	y, Town or Lo								10d. Inside City Limits
	a-f st	ctor	Maryland N	'A		Balt	imore							1 X Yes 2 ☐ No
	or 28	Oire	10e. Street and Number				10f. Zip		220		1	og. Citizen of U.S		intry?
	ath w	rai	241 East Grinda		Fire in 11	6 13	Was Dasad		230	ain? (Specify)	Vas or No-			can Indian,
21215-0036	be filed within 72 hours after death with the Maryland by given by by given by death of the than "naturel", or items 23a or 28a-f show do other than "naturel", or items 23a or 28a-f show event, I're Mouleal Exactions on the restilled at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 MYes 2 If Yes, Give Year or Dates:	?		was Deced If Yes, spec		Specify:	gin? (Specify ` i, Puerto Ricar	n, etc.)		ck, White	
9-0	72 ho	Completed	15. Decedent's (Specify only highest of			(Give	dent's Usua	rk done d	uring most	t of working		16b. Kind of B	usiness/li	ndustry
21	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT us	e retired,)			W.R. G	race	& Co
2	filed wi Hygien ther th	Co	10	U		Cn	emical	r Obe		r's Name (Fir	st Middle I			& CO.
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, tra Mi	To Be	17. Father's Name (First, Middle, La Thomas Coa	ates						rginia	_	ay		
ary	should and Men s marke umatic		19a. Informant's Name/Relationship							er or Rural Ro				
	1 and 2 Health a tem 27 is		Mildred D. Coate	es (Wife)					iall					yland 21230
ore	of He of He if item		20a. Method of Disposition 1 Burial 2 □ Cremation 3	☐Removal from State		Place of Dispo cometery, cre	matory or o	ther place		Date		20c. Location	-	
Ë	Pages Iment of I lant: If its jury or o		4 □ Donation 5 □ Other (Spe	cify)	Mea		-			02-28-0				aryland
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Service Lie	8 Han	ent.								ryla	nd 21230
4	Physician /Medical		23a. Pant. Enter the disease, or connect, or heart failure. List or lumediate Cause (Final disease or condition resulting in death)	a. Due to (or a	ine.	ary			g, such as		spiratory arr	est,		Approximate Interval Between Onset and Death
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseq	juence of):								
4	ite be executed ysician and ne burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C		wanaa of):								
760,	oe execian a	E	resulting in death) Last	Due to (or a	s a conseq	querice or):								
	physic the b	dicai		d										
O. Box 68	ne death certificate be executed the attending physician and ched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 12 No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	al death 3	□Ectopic p □ Other (sp						ate of deli	very Day Year
ds, P.O	requires that the der een signed by the a hould be detached f	b	Part II. Other significant condition	s contributing to death	but not res	sulting in the	underlying o	ausa giv	en in Part I	l.		bacco use co es 2 □ No	ntribute to	the cause of death?
Records,	e law has b ge 2 sl	Completed			_						24a. Was a autop perfor 1 ☐ Yes	an 24b sy mad? 2 1 No	Were au prior to death?	topsy findings available completion of cause of
Vital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical			7000			26. Place	e of Death Cl	heck only o	ne)		
1	Z 20	To	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Umpa	tient 2] ER/Outpatie			4 🗀 N	ursing Home				city)
0	fei ng		27. Manner of Death 1 Autural 5 Pending	28a. Date of in (Month, L	jury Day Year)	28b. Time Injury		28c. Injur Wor			Describe h	low injury occi	ırred	
Sio	Attending in death. ector: After by the fune	cati	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no		A. h.		M		Yes 2□		Location /9	Street and Mun	her or Ru	ural Route Number,
Division of	or Att	Certification:	4 Homicide determin	289. Place of I	etc. (Speci	ify)	treet, ractor	у, опісе		281.	City or Tow		iber or m	na riodie rumber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai Co	29a. Certifier 1 Certifying (Check only one)	Physician: To the bes xaminer: On the basis and manner	of examin	owledge, dea ation and/or i	th occurred investigation	at the tir	ne, date ai pinion, dea	nd place, and ath occurred a	due to the dat the time, d	cause(s) and r date and place	nanner as e, and due	s stated. to the cause(s)
	within 2 To the comple	Med	29b. Signature and litle of certifier	1 //					e number		100	29d. Date sigr	2.0	
	⊢ \$ ⊢ ŏ		12-	(for)				P/9	74	5		Feb	24	2005
	nvl		30. Name and address of person w	no comple cause o	f death (Ite	m 23a) (Type	e, Print)		1.1.				-	200 5 70 21201
	1/1		University or	Marylan	1/10	execul	Cente	5 ~	286	rane	St 6	saltm	re, i	10515 07
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		-	For State Registrar	State of	Maryland / De	-	ment of He cate of D			giene Reg No	006	05710
3 X	Physici	_	1. Decedent's Name (First, Middle William Chon	, Last)					2. Date of Dea Month 02/19/	Day	Year	3. Time of Death 9:44 P
	/Medio Examin		4a. Facility Name (If not institution Anne Arundel Medic		ber)	A	nnapolis	Location of Death		Ann	County of Death e Arundel	
	Funeral Director		5. Social Security Number 216–76–8787	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. last birtho	Mo	Under 1 Year onths Days	Hours Min.	8. Date of Bird (Month, Da 04/28/19	y, Year)	Cou	place (State or Foreign ntry) Korea
	Maryland -f ahow lied at	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne A	Arundel	10c. City, Town o							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the	ai Director	10e. Street and Number 7900 Benesch C	ircle # 81	7	11	0f. Zip Code 21060			10g. Citiz	zen of What Cou USA	intry?
980	172 hours after death with the Maryland "natural", or itema 23a or 28a-f ahow valical Expenier chart be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☑ Divorced	Armed For 1 ☐ Yes ff Yes, Give	ces? 2 [XNo e	If Yes	Decedent of His s, specify Cubar Yes 2 X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		14. Race - Amer Bfack, White Specify: AS	, etc.
21215-0036	within ane. Ihan	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1-	(C	Give kind fe. DO N	s Usuaf Occupa I of work done d VOT use retired)	uring most of work	ang		ail Sto	
and 2	be file stal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Sung Suk Chon					18. Mother's Nam Oak Da	e (First, Middle, an Kim	Maiden	Sumame)	
Maryland	and and ls m	F	19a. Informant's Name/Relations Steve Chon / So					nd Number or Rui				ip Code)
Baltimore,	m O		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (S		20b. Place of D cemetery, Norbeck	cremato	ry or other place	02/25/	Date 2006		cation - City or I	
Balti	permit. Page Depertment important: If any injury or once.		21. Signature of Funeral Service		MO1378	322. Na 32ry 1 7250 1	me and Addres L. Kauling Washingto	n Funeral n Blvd., E	Home at M Ikridoe,	feedow MD 21	ridge Men .075	orial Park, IN
8760, <	Physician /Medical Examiner pub personal properties of the personal proper	dical Examiner	23a. Part1. Enter the disease, of shock, or head failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ASP one to (c) b. Dy 3 Due to (c)	PHAGIA or as a consequence of) PHAGIA or as a consequence of) EBROVA- or as a consequence of)	:	PNE	umodi	A			Interval Between Onset and Death
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ds, P.0	uires that the signed by	þ	Part tf. Dther significant condition	ons contributing to de	ath but not resulting in the	he under	lying cause give	on in Part I.		obacco u Yes 2		the cause of death?
of Vital Records,		Completed							24a. Was auto perto 1 🗆 Yes		prior to death?	topsy findings available completion of cause of
Vita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:	odeno.		Othe	26. Pface of Dea			C Cloth or (Cook	
	ing Phys	ion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir	28a. Date of (Mont	npatient 2 ER/Outp. of Injury h, Day Year) 28b. Tin Inju	ne of	28c. fnjury Work		28d. Describe		6 Other (Spec	ary)
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At home, farming, etc. (Specify)			22.10	28f. Location (City or To			ral Route Number,
	n 24 hours n 24 hours ne Funerel	edical C	29a. Certifier (Check only one)	Examiner: On the ba	best of my knowledge, or asis of examination and/or stated.	or invest	gation, in my op	oinion, death occu	rred at the time,	date and	place, and due	to the cause(s)
	To the within to the total comp	M	29b. Signature and title of certified Management 29b.	in, MI	>		D 5	753)		FE	te signed (Month	200 6
	Sta Regist		30. Name and address of pe/sol Mohat No. 31. Date filed (Month, Day, Yean FEB 2	who completed caus 91 , 260 32. R	e of death (Item 23a) (Ty VC TC 0 15 egistrar's Signature	ype, Prin	wy, 8	uiti 20	y m	ille	rsitte	, MD 2108

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and	Mental Hygiene
Cartificate of Death	6000 001

			1 = For State Registrar		Otate of	iviai y tai		tificate of				eg. No.	16	U5/	
	Physici	an	Decedent's Name (Firs	t, Middle, Las	1)					1	Date of Deat Month	Day	Year	3. Time of	
	/Media				. Cykmar						'ebruar	y 22,		3:37	Рм
i	Examir	er	4a. Facility Name (If not in University			ner)			imore	Death		4c. County n/a			
	Funeral Director		5. Social Security Number 217 98 6231 Usual Residence of Dece	1[x 7. XM 2□F	Age (In yrs. 25	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, VOV 14	Year)	Cour	lace (State o try) Land	r Foreign
Po el	A H			County		10c. Cit	ty, Town or Lo	cation					1	0d. Inside Ci	
a Mon	1-0	ctor	MD H	Ioward		Ca	olumbia	ı						1 🗆 Yes	2 4 0
Acceptable of the though	23e or 28	Funeral Director	10e. Street and Number 9053 Watch	Light	Court			10f. Zip Code 21045	5		1	og. Citizen of Unite		•	
3	*naturel", or lieme 23e or 28e-f ehow adical Examiner must be notified at	by Funer	11. Marital Status 1 XNever Married 2 3 Widowed 4 D		12. Was Deced Armed Forc 1 Tes 2 If Yes, Give Year or Date	es? [X No	l l	Vas Decedent of H Yes, specify Cub ☐ Yes 2X No	dispanic Orig an, Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No- an, etc.)		ce - Americ ck, White,		
3-0036	ature		15. D	ecedent's Ed	ucation		16a. Deced	ent's Usual Occur	pation	-4		16b. Kind of B			
Z	- Neg	Completed	Elementary/Secondary		de completed) College (1-4	or 5+)	life. L	kind of work done OO NOT use retire	d)	or working			-	-	
7	al Hygiene. cother than		17 Feebada Nama /Fine	Adiddto (ast)	1		Bil	ling Cle		ria Alama (F	innt Adiddle A		ploye	<u>sd</u>	
- 4	i and Mental F is marked of raumatic ever	To Be	17. Father's Name (First, Jonathan J.		n						. LaPla	^{Maiden Sumar} ante	ne)		
	John Treass I must should be list with most most of the list and Mental better the most of the list and marked other than any injury or other traumatic event, the Manages.		19a. Informant's Name/R Jonathan J.			•		g Address (Street Flagstor							
ш .	Health Item 27 other tra		20a. Method of Dispositio	n		20b. F		sition (Name of natory or other pla	CONTRACTOR OF STREET	Date	1,217162	20c. Location			·
	ment c ent: If ury or		1 ☐ Burial 2 💆 Cred 4 ☐ Donation 5 ☐ C			ate		matory		2-25-2	2006	Catons	ville	e, MD	
	Department of himportent: If Ite eny injury or of once.		21. Signature of Funeral	Service Licen:	o - Wt	CMO1		. Name and Addre							
ï			23a. Part1. Enter the disc shock, or heart failu	ease, or comp	lications that cal	ised the deat						_		Approximate Interval Bet	e ween
	hysician		Immediate Cause (Final disease or condition		· Mu	Otis	ell	Thise	rie					Onset and I	Death
	/Medical xaminer		resulting in death)		Due to (or	as a conse	uence of):	9							
ı		je.	Sequentially list condition	ns,	b. — Due to (or	as a conseq	luence of).								
Pot.	ansit	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	***			,00.100 01,1								
U,	ng physicien and as the burial-transit		that initiated events resulting in death) Last		Due to (or	as a conseq	guence of):								
DA 68/60	physical the bu	Medical			d.					-					
×	ding p		IF FEMALE:		23c. If yes, outco	me of pregna	ancy					23d Da	ate of delive	10/	
מ פֿ	ne etter	Physician/	23b. Was decedent pregi in the past 12 month 1 ☐ Yes 2 ☐ No	i i atrit	1 ☐ Live birt	h 2∏Feta ntattime ofd	I death 3	Ectopic pregnanc Other (specify) _	у				onth		ear ear
ָר פֿ ס	d by the	Phys	9 Unknown	oonditions of			. Min min ab a	4.47	in Mant		02- Did tol		Adhiis so M		l==45.0
ecords, P.O	requires that the death of the estending should be detached for use	þ	Part II. Other significant	conditions co	ontributing to dea	th but not res	culting in the ur	iderlying cause giv	ren in Part I.			bacco use con es 2 vo		ably 4 ∐L	
0 9	2 8 6	plet									24a. Was a autops	n 24b.	Were auto	psy findings a	available
r	ete h page	Completed									perform	med?	death?	2 No	au36 01
or vital	certificate	Be	25. Was case referred to examiner?		Hospital:	_		- 10#			heck only on				
	or this	7; To	1XXes 2 No 27. Manner of Death		28a. Date of (Month,		ER/Outpatien 28b. Time of	t 3 DOA 28c. Inju	4 🗀 1901			ence 6 □Oth		e home	1
פוסו	r death. ector: After by the funer	atloi	1 ☐ Natural 5 ☐ 2 ☐ Accident	Pending investigation	- 1 -	Day Year)	Injury 15:05		rk? ∣Yes 2. 🔀 N	No D	COGNO	Juga	2000	2 read	
= 7	2 6 6	Certification;	3 Sutcide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place o	Injury - At h	ome, farm, str	eet, factory, office			City or Towr	reet and Numi	blk.	E con1	per d
2000	4 T S	edical C	29a. Certifier 1 (Check only one)	Certifying Phy Medical Exam	iner: On the bas	est of my kno	wled a eath	occurred at the tivestigation, in my o	me, date and opinion, deatl	place, and h occurred	due to the ca	ause(s) and m	anner as s	ated.)
4	within 24 h To the Fur completely	Med	29b. Signature and title o	t certifie	and manne	r stated.		29c. Licens	se number		2	9d. Date signe	ed (Month,	Day, Year)	
,	510		1	M	HX	M		0.0	.M.E.		1	ebruary			
,1	1		30. Name and address of	person who	completed cause	of death (Iter	m 23a) (Type,	Print)							
4			5.12.	1100	AN			nn Street	t, Bal	timor	e, Mar	yland	2120	L	
	Sta Registi		31. Date filed (Month, Da FEB			istrar's Signa		and a							
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			For State Registrar	State	of Maryla		partment of I ertificate of			ene 2 No 0 6	05	712
			Decedent's Name (First, Middle)	, Last)					2. Date of Death			me of Death
	Physici /Medio		Carl Carter						February	•	oar 06 4:1	10 AM ^M
	Examin		4a. Facility Name (If not institution		ımber)		4b. City, Town, o	or Location of Death		4c. County of		
			St. Thomas	More Nurs	sing Ce	nter	Hyatts	ville		Prince	George'	s
	Funeral		5. Social Security Number	6. Sex	7. Age (In yı	s. last birthda	Months Days		8. Date of Birth (Month, Day,	Year) 9.	Birthplace (St Country)	tate or Foreign unk
١.	Director		345-58-5792	1₩ 2□F	47	Yrs.			Nov 2, 1	1958		
	and w		Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or	Location				10d. Insi	ide City Limits
	f sho	ō	MD Prin	ce George	1.	Hyatts	erri 11a					Yes 2 No
	28a	Director	10e. Street and Number	ce dedige	. 0	nyacca	10f. Zip Code		100	g. Citizen of Wha		A
	3a or	٥	4922 LaSalle R	oad				20783		USA		
	ma 2	Funerai	11. Marital Status		cedent Ever in		3. Was Decedent of I	Hispanic Origin? (St	pecify Yes or No-	14. Race -	American India	an,
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or itema 23a or 28a-f show event, the Medical Examination must be notified at	by	1 X Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	Armed F ied 1 □ Yes If Yes, G Year or	2 □ No ive	unk	1 ☐ Yes 2X No	san, Mexican, Puerto Specify:	Hican, etc.)		White, etc. b1ack	
Ď	72 ho	Completed	15. Deceden		1	16a. De	cedent's Usual Occu	pation	unk 1	6b. Kind of Busin	ess/Industry	unk
21	within 7 lene. than "r	npie	Elementary/Secondary (0-12)	1	(1-4or 5+)	life	e. DO NOT use retire	daning most of world)	King			
	filed wi Hygien other th	ပ္ပ	unk	unk								
and		Be	17. Father's Name (First, Middle,	Last)			unk	18. Mother's Nam	se (First, Middle, Ma	aiden Sumame)		unk
Maryland	d 2 should be the and Mental I is marked of traumatic even	2	19a. Informant's Name/Relations	nip (Type, Print)		19b. Ma	ailing Address (Stree	and Number or Ru	ral Route Number,	City or Town, Sta	ite, Zip Code)	
	2 2 2		St. Thomas More	Nursing	Ctr	49) 22 LaSall	e Road Hy	attsville	. MD 2	0783	
altimore,	of H	1	20a. Method of Disposition	0. 🗆 🗆		. Place of Dis	sposition (Name of crematory or other pla		Date 20	0c. Location - Cit	y or Town, Sta	ate
Ĕ	Pages nent of nnt: If It ury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other (S	oecify) in√st	ate	•	,	1				
Balt	permit. Page Department of Important: If any injury or once.		21. Signal of Funeral Service	Licensee	Direct	1	22. Name and Addr State Anat	comy Board			e Stre	et
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the de	eath. Do not	Baltimore, enter the mode of dy	ng, such as cardiac	or respiratory arres	st,	Approx	ximate at Between
	Physician		Immediate Cause (Final disease or condition	only one cause on	each inte.	t2.4°	7. C.	12725-711106/	111	(2)	Onset	and Death
	/Medical		resulting in death)	aDue to	o (or as a cons	equence of):	4904	mon	Nec	4 NOW	7	airs
	Examiner		Sequentially list conditions.	b					Nec	R.	,	
	ed sit	Jiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a cons	equence oi):						
	and and li-tran	Examin	that initiated events resulting in death) Last	c. Due to	o (or as a cons	equence of);						
8760	icate be executed physiclen and s the burial-transit	aiE										
89		edicai		0.						1.		
Box	death certific e attending p od for use as t	2	IF FEMALE: 23b. Was decedent pregnant		utcome of pre		205-1			23d. Date of	f delivery	
	0 00	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 ☐ Fo gnant at time o		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	;y		Month	Day	Year
o.	at the de by the s stached	hys	9 Unknown	1								
	igned I	by	Part II. Other significant condition	ns contributing to	death but not i	resulting in th	e underlying cause gi	ven in Part I.		cco use contribu		
ecords,	w requir been si should I	ted							1 MYes	2 □ No 31	Probably	4 Unknown
r	has be ta	Completed							24a. Was an autopsy perform	ed? dea	re autopsy find r to completion th? Yes 2 No	
N N	sician: Th certificate irector, pag	Bec	25. Was case referred to medica					26. Place of Dea	th (Check only one		103 20 110	
>	Physic this ce al direc	To E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2	☐ ER/Outpa	tient 3 DOA	her: 4 Mursing H	ome 5 🗆 Resider	ice 6 Other	(Specify)	
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date (Mo	of Injury nth, Day Year	28b. Time Injur		ry at ork?	28d. Describe hov	v injury occurred		
<u>S</u>	Attendideath. ctor: A y the fu	cati	2 Accident investi	gation			M 1]Yes 2□No				
Division of	or Attending Physicians after death. Director: After this certific in by the funeral director,	ertification:	4 Homicide	ined 288. Plac	e of Injury - A ding, etc. (Spe	t home, farm, ecify)	street, factory, office		28f. Location (Stre City or Town,		or Rural Route	Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	O	29a. Certifier 1 Certifyir (Check only 2 Medical	g Physician: To the	ne best of my l	enowledge, de	eath occurred at the t r investigation, in my	ime, date and place	, and due to the cau	use(s) and mann	er as stated.	usea(s)
	the H hin 24 the F mplete	Medicai	one)	and ma	nner stated.							
	T W I		1 Amel	and	elh		D	0185	2 2	d. Date signed (/	L/1 7	LOAK
			30. Name and address of person	who completed of	use of death (I	tem 23a) (Ty	pe, Print) P 223 Q	200 A	1. 0 11	1 Hz	1/0 1	12020
	Sta	to	31. Date filed (Month, Day, Year)	JEVE 32.	Registrar's Sig	nature	w 5 40	CENSO	ing real	179 436	JIME "	الم الله
	Regist			2006	Registrar's Sig	& A	osale)					

		1	For Stete Registrar	State of Ma				of H	ealth a		•		7 11 11	6	05	113
			1. Decedent's Name (First, Middle, Las	t)							2. Date of D	eath Da	v	Year	3. Time	of Death
	Physicia /Medic		Olga D. Dukehai	rt							Februa			2006	1:20	PM M
,	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, 1	Town, or	Location o	of Death		4c	. County	of Death		
			Greater Baltimore					owsc	n		,		Baltj	more		
	Funeral		5. Social Security Number 6. Se	הא מר י יר		ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bi (Month, D 08/06)	/1 920	,	9. Birthp	place (State	or Foreigi 4
	Director	-	214-16-3627 Usual Residence of Decedent		35	113.					U8/U6,	/ 1920	7	Mai	rýlano	1
	land ow	-	10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside	City Limits
	Mary 1 eh	ğ	MD Baltimo	ore	Cock	keysvi	lle								1 🗍 Ye	s 2X No
	r 28s	lrec	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of V	Vhat Cour	ntry?	
	h wit	0	11113 Pool Road				2	1030					US	Α		
2	is 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mentel Hygiane. If health and Mentel Hygiane. The marked other than "naturel", or Iteme 23a or 28a-f show leter traumatic avent, the Madical Evandrar must be multiled at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent! Armed Forces? 1 Yes 2 If Yes, Give X Year or Dates:		1	Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:	gin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	0-		k, White,	ean Indian, etc. White)
3	hour	ed	15. Decedent's Ed			16a. Dece	dent's Usua	I Occupa	ation			16b. K	Cind of Bu	usiness/In	dustry	
2	in 72 n "na Aartis	Completed	(Specify only highest gra	de completed)		(Give	kind of wor DO NOT us	k done d e retired	turing mos	t of work	ing				,	
7	i with	EO	Elementary/Secondary (0-12)	College (1-4or 5	0+)	Hom	emake:	Г					Own	Home		
2	othe vent,	Be C	17. Father's Name (First, Middle, Last)								e (First, Middl		Sumarr	10)		
2	Mente Mente rked ric a	To E	Nicholas Drago	nuk					Hele	en l	Kotlows	KI				
<u></u>	2 6 5 6		19a. Informant's Name/Relationship (1				_				al Route Num					70
	of Health Item 27		Russell Dukehart	(spouse)	1						ckeysvi	-				
Dalillior	permit. Pages 1 Deperiment of H Importent: if Ite any Injury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	C	lace of Dispo emetery, cre .aney	matory or or Valley	Mei Mei	m Gar	dens		T	imon	ium,		
0	Depermit Depert Import any In			tephen D.		er .		York	Road	i, Tc	ıck Tow wson,	Mary			14	
	Physician		23a. Part1 Enter the disease, or composition, or heart failure. List only Immediate Cause (Final disease or condition			n. Do not en ruRY				cardiac	or respiratory	arrest,			Approxim Interval B Onset an	etween d Death
1	/Medical		resulting in death)	Due to (or as	a consequ	uence of):										
	Examiner		Sequentially list conditions,	b												
	Da #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	uence of):										
	and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):										
Š,	te be executed ysiclen and le burial-transit	calE														
000	ficate phys s the			d												
O. DOX .	w requires that the death certificate be executed to been signed by the ettending physicien and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	I death 3	⊒Ectopic pr ⊒ Other (sp							te of deliventh	ery Day	Year
ŗ	requires that the een signed by th hould be detache	y Ph	Part II. Other significant conditions of						en in Part	l.	23e. Did	tobacco	use cont	ribute to t	he cause o	f death?
coras	quires n sign	d by	Lung Cane	-bost a	ren	10 4	XRT				15	¥es 2	!□No	3 🗆 Pro	bably 4	∐Unknown
รู	law rec as bee 2 shou	Completed	Renal Raw	2009							24a. We		246.	Were aut	opsy finding	as available
Ē	0 5 0	E									per	opsy formed?		prior to co death? 1 □ Yes	mpletion o	t cause of
N I I	ilcian: Th certificete rector, pag	0	25. Was case referred to medical						26. Plac	e of Deat	th (Check only		3	1 🗆 1 63	١٧٥	
	2 40 5	0 8	examiner?	Hospital:	ent 2 🗆	ER/Outpatie	nt 3 DC	Oth Oth	00		ome 5□Re		6 □Oth	er (Speci	fy)	
0	ig Phys ter this neral dii	n: T	27. Manner of Death	28a. Date of Inju	ry v Year)	28b. Time o	of 2	8c. Injur Wor	y at k?		28d. Describe	e how inj	ury occur	red		
ğ	Attending r death. ector: After by the fune	atic	1 Accident 5 Pending investigation	n		,,	М		Yes 2□	No						
DIVISION	al or Attending Phy i effer death. I Director: After thi d in by the funeral d	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of In building, e			treet, factory	y, office			28f. Location City or T	(Street a own, Sta	nd Numb te)	oer or Rur	al Route N	umber,
	To the Hospital or Attendi within 24 hours effer death. To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysicien: To the best niner: On the basis of and manner st	of examina ated.	tion and/or i	nvestigation	at the tir	ne, date a pinion, de	nd place, ath occur	, and due to the	e cause(e, date ar	s) and mand place,	anner as and due	stated. to the caus	e(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	Zandel	,	nd his	290		S&	0,2			-	d (Month	Day, Year)
	10		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type	, Print) 12	205	- PC	RK.	RO	10	211	33		
	Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ature										
	Regist		FER S 1	2006	KARA .	M. A	1000 L									
DH	MH 17 Rev 1/2	rara 1														

DHMH 17 Rev 1/2001

			1 – For State Registrar	State of Marylar		ent of Health and ate of Death		giene	05714
			1. Decedent's Name (First, Middle, Las	t)			2. Date of Dea	ith	3. Time of Death
	Physici		CAGSIE	VIRGINIA	EDINA	RDS	Month FEB	24 2000	60135AM
	/Medic Examir		4a. Facility Name (If not institution, give			ty, Town, or Location of Dea	th	4c. County of Dea	
			GILCHRIST	HOSPICE		BALTIM	ORE	1	VA
	Funeral		5. Social Security Number 6. Se	9x 7. Age (In yrs.		ler 1 Year If Under 24 Hrs	8. Date of Birth	9. Bir	rthplace (State or Foreign ountry)
	Director		217-52-3746	DM 200 F 5	Yrs.	s Days Hours Min	JULYOC	,1950 /	IARULAND
	B		Usual Residence of Decedent	10. 0	-		/	/	/
	anylar ahow	_	10a. State 10b. County		ty, Town or Location	12	. 0	/	10d. Inside City Limits
	the Ma 28a-f	cto	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	/A	X	DALTIMO.	RE CI	TY	1 XYes 2 No
B	with the Maryland a or 28a-f ehow	Sire	10e. Street and Number	/	10f. 2	Zip Code		10g. Citizen of What C	•
1	€ 23 €	rail	6659 SPR11	VG MILL CIA	CLE	212		USA	
5	e E	ne	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was Dec	cedent of Hispanic Origin? (Specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	
36	or la	γF	1 Never Married 2 Married	1 ☐ Yes 2 X No ff Yes, Give		22 No Specify:		Specify:	
0/ 5-0036	hours after lural', or Ite	d b	3 ☐ Widowed 4 ⚠ Divorced	Year or Dates:	1 10 2			130	LACK
<u> </u>	in 72 "nat	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Decedent's Us (Give kind of life. DO NOT	work done during most of wo	orking	16b. Kind of Business	s/Industry
2121	y withir piene. r then	m	Elementary/Secondary (0-12)	College (1-4or 5+)	10	SS EDUCATION	TE ANI - D	1-000-	OF CORRECTIONS
			17. Father's Name (First, Middle, Last)	11D(DIYE)	OUSING		me (First, Middle,		OF CORRECTIONS
an c	T to to	Be	TANK	GILB	POT	0-			1=10=
/o 6 a		2	19a. Informant's Name/Relationship (7			ess (Street and Number or R	LDINE Jural Boute Number		TELDS
^ a	nd 2 sho eith and 27 ie m ir treum		1	KS DAUGHTER	100	43			
	1 end Heelth em 27 ther tr	2	20a. Method of Disposition			KOUND ROAL	Date	20c. Location - City of	
774 more,	<u> </u>	١.,	1⊠Burial 2 ☐ Cremation 3 ☐	Hemovai from State	Place of Disposition (Accemetery, crematory of	11	.4 ./	ACTIFIC .	
	permit Peg Department Important: any intury conce.		4 Donation 5 Other (Specify		LISUTUS (EMETERY 3-	03-06	AKBUTUS	MARYLAND
Bal	permit Depare Import any in		21. Signature of Funeral Service Licen	11 11 Main	22. Name	and Address of acility	ROWN	JK. FUNE	KAL HOME
-			23a. Part1. Enter the disease, or comp	1. William	0/0/19				MP-2/2/7 Approximate
527.1			shock, or heart failure. List only	one cause on each line.			ic or respiratory ar	.est,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a 13501	AST CA	1cer			years
	/Medical Examiner		Tosting in dodain	Due to (or as a consec	quence of):				0
34		-	Sequentially list conditions,	b. — Due to (or as a consec	outer all				
+ 0	De #1	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Date to for as a consec	juanca ory.				
9	and and I-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	ruence of):				
6.4 8760,	cate be executed thysiclen and the burial-transit				,				
687	age ⊱ et	dicai		d					
9 X0	leath certifica attending pl	Completed by Physician/Me	IF FEMALE:	23c. If yes, outcome of pregn.	ancy			004 0-4-44	e
48	death (le atten ed for u	jan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 Ectopic			23d. Date of de Month	Day Year
Q o	0 0 0	ysic	1 Yes 2 No 9 Unknown	9 Unknown	ieatii 5 Cilier	(Specify)			
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ds,	w requires that been signed to should be det	υ δ			,		101	<u>.</u>	robably 4 Unknown
\$ 5	requ	ete					ļ -		
) ¢	e law hes t	Įd.					24a. Was autop	an 24b. Were a prior to	utopsy findings available completion of cause of
\(\frac{1}{2}\)							perfor	rmed? death? 2 No 1 ☐ Ye	
ED WA	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			eath (Check only or	16)	- 11
, j o	0 v 0	၉	1 ☐ Yes 2 X No	1 Inpatient 2	ER/Outpatient 3		Home 5 Resid		ecity) HOSPICE
Ψ =	B le le	on	27. Manner of Déath 1 Naturaf 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	now injury occurred	V
4551E Division	Attending r death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be		M	1 Yes 2 No	001 1		
SE	or Al ftar c Sirec in by	Ŧ	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str <i>ee</i> t, fact fy)	ory, office	City or Tow	Street and Number or F m, State)	iural Houte Number,
640	To the Hospital or Attendi within 24 hours aftar death. To the Funeral Director: A completely filled in by the fo		29a. Certifier 12 Certifying Ph	luciolem To the Land					
9	Hoe 24 ho Fun fely i	edical	(Check only 2 Medical Examone)	ysician: To the best of my kno niner: On the basis of examina	owledge, death occurrention and/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the curred at the time, o	:ause(s) and manner a date and place, and du	is stated. le to the cause(s)
	thin the	Med	29b. Signature and titferof certifier	and manner stated.		29c. License number		29d, Date signed (Mon	
	F × F S		Martin	ulliven an				Februar.	24 2006
	G_{i}		- Al LINI ILAN	y low jo		10000	/	- DIVAY	1,000
	10		30. Name and address of person who	completed cause of death (Itel	m 23a) (Type, Print))25205 V. Charles.	G Ro	lto out	20208
			31. Date filed (Month, Day, Year)	32. Registrar's Sign		7 0 0000	37 . 1200		
	Sta Registi		FFR 2 7 200	16 Herrica A	LANGAGA.				

			1 - State of Maryland / [nent of H			giene ()	6	05715
	, Ag		Decedent's Name (First, Middle, Last)				2. Date of Dea	ath		3. Time of Death
	Physici /Medic		Mary Rita Eulert				Month Februar	Day 19 2	Year 2006	10:40 AM
	Examin		4a. Facility Name (If not institution, give street and number)	4b.	City, Town, or	Location of Death	1001001	4c. County		10.40 AN
			Atlantic General Hospital		Berlin			Wor	cest	er
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir		Inder 1 Year oths Days	ff Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h v, Year)	9. Birth	place (State or Foreign ntry)
3	Director		216-20-0845 80 Usual Residence of Decedent	115.			July 2	5, 1925	_Mar	yland
	show		10a. State 10b. County 10c. City, Tow	vn or Location	1				T	10d. fnside City Limits
	Man,	to	MD Worcester B	Berlin						1 ☐ Yes 2 ☐ No
	h the	Director	10e. Street and Number	10	f. Zip Code			10g. Citizen of	What Cou	ntry?
	th wit	a D	110 Franklin Avenue		,	21811		US	٨	
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was D	Decedent of Hi	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)			can Indian,
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No ff Yes, Give		es 2∑ No	Specify:	, , , ,	Specif		
Ö	illed within 72 hours after death with the Maryland Hygiene. ither than "naturel", or Itema 23s or 28s-1 show int, I'm Marijcal Examerator mat be mailified at		3 ▼Widowed 4 □ Divorced Year or Dates:			*:			WILL	
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212	with liene.	E O	Elementary/Secondary (0-12) College (1-4or 5+)	secre				2112	aina	homos
þ	be filed htal Hygi ad other event, L	BeC	17. Father's Name (First, Middle, Last)	30016	cary	18. Mother's Name	(First, Middle,			homes
Maryland 21215-0036	0 5 5 0 e	To B	Thomas Hayden Williams			Myrle Ir	ene You	ne		
ary	s 1 and 2 should if Health and Mer Itam 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b	b. Mailing Add	dress (Street a	nd Number or Rura			State, Zip	Code)
	and 2 ealth a m 27 is		Nancy Lawn/daughter	126 Oc	ean Pai	ckway Ber	lin. MD	21811		
ore	of He fitan roth		20a. Method of Disposition 20b. Place of	of Disposition	(Name of or other place		ate	20c. Location	City or T	own, State
<u>Ĕ</u>	Pages ment of i ent: if its ury or o		4 ☑ Donation 5 ☐ Other (Specify)							
Baltimore,	permit. Pages 1 Department of h Importent: if its eny injury or ot		21. Signature of Funeral Service Licensee Ronald So Wade, Director	State	ne and Addres e Anato imore	s of Facility Omy Board MD 2120	655 W.	Baltim	ore S	Street
	- 1.00 ±		23a. Part1. Enter the disease, or combications that caused the death. Do shock, or hear failure. List only one cause on each line.					rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Stick feet	il m		un	•			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence	of):	1/	1				
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	pe tis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of):						. •
2006 50,	and and I-tran	Examiner	Cause (Disease or injury that initiated events c	of).						
19/20 18760,	cate be executed physicien and the burial-transit		Due to (or as a consequence	OI).						
191	phy	dlcal	d							
// 2 ×0	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy					22d Da	te of deliv	200
, B	death atter	clar	in the past 12 months?		oic pregnancy or (specify)				nth	Day Year
, & O.	it the d by the tached	lys	1 Yes 2 No 9 Unknown 9 Unknown		(5,555)					
250	The law requires that the death certifite has been signed by the attending rage 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in	in the underly	ing cause give	n in Part I.	23e. Did to	bacco use cont	ribute to t	he cause of death?
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7/25/ Reco	law re as be 2 sho	plet					24a. Was	an 24b.	Were auto	psy findings available mpletion of cause of
7 %	The Tate has page	Completed					autop perfor 1 Yes	med?	orior to co death? I □ Yes	
0845 Vital	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. Place of Death				2010
+=	ting Physicien: After this certific funeral director,	10	1 Yes 2 Hospital: Inpatient 2 ER/Ou	utpatient 3[□ DOA Othe	4 Nursing Hor	ne 5 Resid	ence 6 Oth	er (Specii	(y)
174 R		ü		Time of Injury	28c. Injury Work		8d. Describe h	ow injury occur	red	
200		cat	2 Accident investigation	M		es 2 □No				
	- 9	Certification:	4 Homicide determined 28e. Pface of Injury - At home, fa building, etc. (Specify)	arm, street, fa	actory, office	2	28f. Location (S City or Tow	treet and Numb n, State)	er or Rur	al Route Number,
Eulert, Din	To the Hospitei or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier (Check only conditions) Check only 2 Medical Exeminer: On the basis of examination and an analysis of examination and an analysis of examination and analysis.	e, death occu	irred at the tim	e, date and place, a	and due to the o	ause(s) and ma	inner as s	tated.
My My	the H in 24 the F nplete	Medical	and manner stated.	id/or investiga						
	To To	2	29b. Signature and title of certifier		29c. License			29d. Date signe		
			connecce		0	(6Z) A		2/	19/0) (
			30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	12,=	16257 MIN, 1	UD 2	1011		
	Sta	to	31. Date filed (Month, Day, Year) 32 Registrar's Signature	ev U.	1	1410/	-	1011		
4	Registr		10324 020 OCEMN CITY B 31. Date filed (Month, Day, Year) FEB 2 7 2006 32 Registrar's Signature	Sparke						

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	ental Hygiene
1. Decedent's Name (Plist, Middle, East)	Reg. No. 2. Date of Death 3. Time of Death
Physician 45 TT15 B FOIER	Month Day Year Q57 AM
Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
4008 Belleview Avenue Baltimore	NA
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Director 2/3-28-9500 1 M 2 M F	APRILIO, 1932 MARYLAND
	10d. Inside City Limits
SALTIMORE BALTIMORE	1 XYes 2 □ No
10a. State 10b. County 10c. City, Town or Location State 10b. County 10c. City, Town or Location 10d. Zip Code 11d. Marital Status 12d. Was Decedent Ever in U.S. 13d. Was Decedent of Hispanic Origin; (Special Code) 10d. Zip Code 10d. Z	10g. Citizen of What Country?
THE YOO & BELLEVIEW AVENUE 21215	USA.
The state of the s	tify Yes or No- lican, etc.) 14. Race - American Indian, Black, White, etc.
10a. State 10b. County 10c. City, Town or Location County Cou	Specify BI ACV
1 Specify: Specify: 1	16b. Kind of Business/Industry
N = e = Elementary/Secondary (0-12) College (1-4or 5+)	
DESCRIPTION OF THE PROPERTY OF	(First, Middle, Maiden Sumame)
a state by a Marian Mar	TE PHILLIPS
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	
2 0000	VE. BALTTHORE, MD 21215
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	ate 20c. Location - City or Town, State
	1-06 WOODLAWN HARYLAND
*4 Donation 5 Other (Specify) *4 Donation 5 Other (Specify) *4 NG MEM. PARK *3 -0 *21. Signature of Funeral Service Licensee *22. Name and Address of Facility 21 4	ON. FUTTON AVENUE MD 21217
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	Funeral Home Baltimore respiratory arrest. Approximate
shock, or heart failure. List only one cause on each line.	Interval Between
Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	allease
Examiner	
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Sequentially list conditions, The same sequence of	
Sequentially list conditions, The same sequence of	
Sequentially list conditions, for as a consequence of): Sequentially list conditions, for as a consequence of): Cause. Chisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d.	
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Sequentially list conditions, fragility of the conditions of the c	23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whiknown 24a. Was an autopsy performed?
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Sequentially list conditions, a say, leading to thin exists, cause. Enter Underlying Co. Due to (or as a consequence of): 23c. If yes, outcome of pregnancy. 1	23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whiknown 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No (Check only one) 1 Yes 2 No 1 Yes 2 No (Check only one) 86. Location (Street and Number or Rural Route Number, City or Town, State) 187. Location (Street and Number or Rural Route Number, City or Town, State) 188. Location (Street and Number or Rural Route Number, City or Town, State)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#4c, pen/IE, C856,6/23/06 TT State of Maryland / Department of Health and Mental Hygiene State Registrar Amend Item #19b Per Ana Bd. Cestification of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 1000 am Willie Foster 13 06 /Medical 4c. County of DeatWicomico 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Somerset 218 S. Tenn Avenue Delmar If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 unk Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**∑**M 2□F Yrs. 22, Director 243-52-7815 67 Mar Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Items 23a or 28a-f show 1 ☐ Yes 2√ No Somerset Delmar Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21875 218 S. Tenn Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status unk 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk than " Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk 19a. Informant's Name/Relationship (Type, Print) Holloway Funeral Home 501 Snow HillRd. Salisbury, Md. 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 ☒ Other (Specify) in state 21. Signature : Funeral Service Litensee Ronald S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 ASCUD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 TYes should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 2 🗆 No 2 No 1 Yes 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

hris

30. Name and address of person who comple

Smyde

FEB 2

DIME

2006

7

DHMH 17 Rev 1/2001

ted cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29c. License number

100E Coursell St.

H50 497

29d. Date signed (Month, Day, Year)

2/16/06

Salisbuy

William Joseph Garrett, Jr. 06-01339 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. crn State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 23,2006 **Physician** 12:45 WILLIAM JOSEPH GARRETT, JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1678 Yakona Avenue Towson Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2/27/1948 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1X M 2 ☐ F Yrs. MARYLAND 216-48-2141 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b County or than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1678 YAKONA ROAD 21286 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Vietnam Specify: WHITE 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) BREAD COMPANY DISTRIBUTOR YEAR ith and Mental Hygie 27 is marked other r traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET BEAVAN WILLIAM J. GARRETT, SR. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health BALTIMORE, MD 2804 EMERALD ROAD WILLIAM J. GARRETT, III/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 2/24/2006 CATONSVILLE, MD METRO CREMATORY, INC. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one puise on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carda Vascuski partlusive atheresclesotic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physicien and s the burial-transit The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): .O. Box 68760, Completed by Physician/Medical as attending | IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 2□No certificate 1K Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ဥ

Division of Vital To the Hospital or Attending Physician: death. I Director: A within 24 hours after of To the Funeral Direct completely filled in by filled in by

Other: $_{4\square \text{ Nursing Home}}$ 5 \square Residence of Other (Specify) at scene 14 Yes 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer. as seeds.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

Certification:

Medical

O.C.M.E. February 23, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1110

111 Penn Street, Baltimore, Maryland 21201

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygierie | | | | = For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** FFBRUARY GOI DEARB 2006 12:55 AM PHILIP /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE JEWISH CONVALESCENT CENTER BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 01/02/1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Yrs. NY 056-14-3087 86 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it a Marical Examiner must be notified at once. 1 Yes 2/ No Director BALTIMORE OWINGS MILLS, 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code U.S.A. 21117 4730 ATRIUM COURT APT. #330 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No WW I I If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 2 WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CLAIMS EXAMINER SOCIAL SECURITY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) **GOLDFARB GRUSHKA** BLIMA **JACOB** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4730 ATRIUM COURT APT. #330 OWINGS MILLS, MD 21117 19a. Informant's Name/Relationship (Type, Print) FLORENCE GOLDFARB / WIFE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/24/2006 MARYLAND VETERANS OWINGS MILLS, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. west 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stape Physician Dumentia /Medical Due to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) ad by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed death? 2 🖼 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Mursing Home 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide To the Hospitel o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Belvere Avenue WEST the ignarials

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 2

7 2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 19a per th g852 2-27-06 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 1:48 AM **Physician** GONZALEZ 23 INA FEBRUARY 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY HOPKINS THE JOHNS HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 213-44-9114 1 ☐ M 2 🕅 F 60 MD 07/12/1945 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 2 should be filed within 72 hours after death with the Maryla and Mental Hygiene. Is marked other then "natural", or fleme 23a or 28a-f ehow surmatic event, the Madical Example or most be notified at 1X Yes 2 □ No Director BALTIMORE N/A MD 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number U.S.A. 21224 8 NORTH ELLWOOD AVENUE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [A] No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: WHITE 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WOMEN'S APPAREL MANUFACTURER REPRESENTATIVE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental FELDMAN SYLVIA DANTZIC JACOB 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nar Gorney and Type, Print) 1758 HAMPTON LANE - PALM HARBOR, FL 34683 Department of Health a Important: If Item 27 is eny injury or other tre once. ALYCIA GONZALES / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ANSHE EMUNAH (ALT EMUNAH) 22. Name and Address of Facility 02/24/2006 BALTIMORE, MD 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. FUNGAL INFECTION

Due to (or as a consequence of): Approximate Interval Between Onset and Death 6 DAYS **Physician** /Medical Examiner 2 WEEKS LIVER FAILURE S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attanding Physician: The law requires that the death certificate be executed 2 YEARS CIRRHOSIS attending physician and tor use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a detached t 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Atter this certificate has I tuneral director, page 2 s autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Sinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: . completely filled in by the I 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number AodaM. Koll RES-000 FEBRUARY 23 2006 , MUS, PHD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 TODD KOLB, THE JOHNS HOPKINS HOSPITAL, GOO NORTH WOLFE STREET, BALTIMORE, MARYLAND

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

FEB 9 7 2006

ORIGINAL

32. Registrar's Signature

			For State Registrar	State of Maryland	•	nt of Health and Nete of Death		ne . 12 0 0 6	05721
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Hackett			2. Date of Death Month	Day Year Z1 200 6	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s University of Mary)	1 4 1 1		Town, or Location of Death		4c. County of Death	1
	Funeral Director		5. Social Security Number 6. Sex 214-78-2148 13			r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) Cou	nplace (State or Foreign untry) RYLAND
	faryland fahow ed at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location	BALTIMOR	ECIT	-,/	10d. Inside City Limits 10d Yes 2 □ No
	with the had a or 28a-	Direct	10e. Styleet and Number	ER STREE	10f. Z	p Code 2 12	109	g. Offizen of What Col	untry?
36	within 72 hours after death with the Maryland ene. than "natural", or ferme 23e or 28e-f show the Medical Exeminar must be notified at	by Funeral Directo		12. Was Decedent Ever in U.S Armed Forces? 1 Yes, Give Yes, Give		edent of Hispanic Origin? (S ecify Cuban, Mexican, Puert		14. Race - Amer Black, White Specify:	
21215-0036	within 72 hou sne. Ihen "natura na Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	life. DO NOT	ork done during most of wor	king 16	Sb. Kind of Business/I	ndustry
	ould be filed Mental Hygid arked other atic svent, I	To Be Co	17. Father's Name (First, Middle, Last)	E. H	FACKET		ne (First, Middle, Ma		ANN
ore, Maryland	d 2 sho th and 17 is m traum		19a. Informant's Name/Relationship (Ty. MICHAEL MANN 20a. Method of Disposition 1⊠Burial 2 □ Cremation 3 □ R	(BROTHER)	136 Solace of Disposition (Nametery, crematory or	other place)	25T. 134 Date 20	LTO, HD	. 2/229 Town, State
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	DR. William	22. Name a	ECEME 2 - and Address of Facility B	27-06 R ROWN JA NAVE. A	ALTIHOR PUNEA BALTO, M	E MARYLAND RAL HOME 10.21217
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death	n. Do not enter the mo	de of dying, such as cardiac	or respiratory arres	ł.	Approximate Interval Between Onset and Death
	/Medical Examiner	<u>_</u>		Due to (or as a consequence). Due to (or as a consequence)					
20, 4	icate be executed physician and s the burial-transit	I Examiner	Cause (Disease or injury	Due to (or as a consequ					
× 68760	death certificate b e attending physion of for use as the b	Medical	IF FEMALE:	J					
O. Box		Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic			23d. Date of deli Month	Day Year
ds, P.O.	ss tha	ρ	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the underlying	cause given in Part I.		cco use contribute to	~
Records,	The ate h	Completed					24a. Was an autopsy performe	prior to d	itopsy findings available completion of cause of
of Vital	sician: certific irector,	Be (25. Was case referred to medical examiner?	lospital:		Other	ath (Check only one)		
of \	Physi this cral dir	1.	1 Yes 2 No	28a. Date of Injury	ER/Outpatient 3☐ [28b. Time of		lome 5 Residen 28d. Describe how	ce 6 Other (Spec	cify)
	ding F th. tuner	tion	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		,,	
Division	et or Attending Physician: s after death. Il Director: After this certifica id in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		ory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	To the Hospital or within 24 hours after To the Funaral Director Completely filled in b	Medical		sician: To the best of my kno ner: On the basis of examina and manner stated.					
)	To th withir To th comp	Me	29b. Signature and title of confier	Ami		9c. License number P 18814		bruary 21	
•	X		30. Name and address of person who co	ompleted cause of death (Item					
	Sta	ate	Michael Albert 31. Date filed (Month, Day, Year)	ompleted cause of death (Item 22 Source 37 Registrar's Signa	this Start	1)0(111100	, , , , ,	-1201	
	Regist		FEB 2 7 200	6 Blown D	SADWARD .				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Day 1, 2006 **Physician** Louis Weber Hoover, Jr. 7:30 a м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Conowingo 556 Conowingo Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊊M 2□ F 212-42-5821 61 Director June 12, 1944 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-4 show other traumatic event, the Medical Examinar must be motified at Conowingo 1 X Yes 2 ☐ No Director Md. Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U.S.A. 21918 556 Conowingo Road Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. White 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐Yes 2 ☐ No tf Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City police officer permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If tem 27 le marked othe any injury or other traumatic avent, QDCB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Oursler Louis Hoover, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 556 Conowingo Road, Conowingo, MD 21918 Anna N. Hoover/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Bel Air Mem. Gdns. 2/25/06 Bel Air, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee 610 W. MacPhail Road, Bel Air, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEHRT FAILURE Physician /Medical Examiner ISCHOMIC HEART DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28c. injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deati To the Funeral Director: filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Andry Novalind mo 205096 FEBRUARY 23, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 126 M. MAIN ST. BELATO, MB 21014 Nowakowski MD ANDREW 32 Registrar's Signature 31. Date filed (Month, Day, Year) FEB 2 7 State 2006 Registrar

06-149	D. Hay	ywa YO	rd ACEMENT	ype or Print in B	lack Inc	delible lnk.	. Ensure Al	I Copies A	re Legible.	
AKG		1	For Stete Registrer	State of Maryland	a / Dopo	tificate of	iodilii dila ii			6 0572
	Physici /Medic		Decedent's Name (First, Middle, Last) Lenora Diana Hay	yward				2. Date of Death Month February		3. Time of Death 8:10 a M
	Examir		4a. Facility Name (If not institution, give s Union Memorial Hos			4b. City, Town, o	or Location of Death		4c. County of Death	
	Funeral Director		210-20-4323	7. Age (In yrs. le	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) July, 2	9. Birth Con	nplace (State or Foreign untry) MD
	death with the Maryland orms 23a or 28a-f show ir revest be notified at	tor	Usual Residence of Decedent 10a. State 10b. County N/.		Town or Lo	cation 1timore				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	3a or 28s	al Director	10e. Street and Number 2714 Guilford A	ve		10f. Zip Code	21218	100	g. Citizen of What Cor	ıntry?
36	rs after deati I', or items 2 xa riner mu	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.s Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Bla	e, etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, It a Medical Examinat must be notified at any Injury or other traumatic event, It a Medical Examinat must be notified at ance.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give life. L	lent's Usual Occup kind of work done OO NOT use retire ing Ass	during most of work d)	ing 16	Sb. Kind of Business/l	
land 21	uid be filed v fental Hygie rked other t tic event, III	To Be Co	12th 17. Father's Name (First, Middle, Last) Oscar Bullock		Iqui		18. Mother's Name	e (First, Middle, Ma e Shepa	_	
Mary	od 2 shoulth and N 27 ia mai		19a. Informant's Name/Relationship (Type Robert Hayward)						City or Town, State, Z	
Baltimore,	Pages 1 ar		20a. Method of Disposition 1 Turial 2 Cremation 3 R 4 Donation 5 Other (Specify)			sition (Name of natory or other pla Nat. Me		14/06	Co. Location - City or Laurel MI	
Bal	Physician /Medical Examiner		23a, Parti Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death re cause on each line.	52. Do not ent	er the mode of dyi	sterstow) ng, such as cardiac	n Rd. Ba or respiratory arres	altimore	MD, 21215 Approximate Interval Between Onset and Death
Box 68760,	tificate be executed ig physicien and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
P.O. Box	he death certif the attending ched for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnanc Other (specify)	y 		23d. Date of deli Month	ivery Day Year
ds, P.	uires that the de signed by the a d be detached t	5	Part II. Other significant conditions con	ntributing to death but not resu	Iting in the u	nderlying cause gr	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Division of Vital Records,	To the Hospital or Attanding Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien completely filled in by the funeral director, page 2 should be detached for use as the burial	Completed						24a. Was an autopsy perform 1 XYes 2	ed? death?	topsy findings available completion of cause of
Vita	ysician:] is certifica director, p	To Be	25. Was case referred to medical examiner?	lospital: 1 XX opatient 2 □	EB/Outpatier	t 3 DOA Ott	hac	th (Check only one	ce 6 ⊟Other (Spec	Print/
on of	tending Physiclan: The leath. tor: After this certificate ha the funeral director, page		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TW	28d. Describe hov		<i>чу</i>)
Divisi	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (sician: To the best of my knowner: On the basis of examinat and manner stated.						
	within Comple	Me	29b. Signature and title of pertifie	WM	1	29c. Licen	se number		d. Date signed (Monti	
	כ		30. Name and address of person who co	ompleted cause of death (Item			et, Balti	more, Ma	ryland 21	201
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 0 3 2006	32. Registrar's Signa						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ARGARET HATCHETT **Physician** 6:00P M 2006 Fignan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Medical Balfinere Couter Merzy If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☐ M 2 🕅 F Yrs. Director 220-18-7261 85 08/24/1920 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in then "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 XYes 2 □ No Maryland <u>Baltimore</u> Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 333 East Lorraine Avenue 21218 U.S.A. death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural; or Iten any injury or other traumatic event, the Mudical Event— 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black ģ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laundry 8 Laundry Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charles James Annie Jennings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 East Lorraine Ave., Baltimore, Maryland 21218 Anna Wilson / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 03/01/2006 1 Burial 2 □ Cremation 3 □ Removal from State taltimore, Maryland 4 Donation 5 Other (Specify) King Memorial Pk. Ceme 22. Name and Address of FacilityThe Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovascular disease **Physician** uean /Medical eral valurar desease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Dahknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t firector, page 2 s autopsy performed 1 Yes 2 No Attending Physicien: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 ☐ Natural 2 ☐ Accident 5 Pending death. 1 Tyes 2 No investigation within 24 hours after death To the Funerel Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 0 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DS6399 Attending 2006 address of person who completed cause of death (Item 23a) (Type, Print)
FEARLYN, MD Welray Weldical Couter 301 St. Paul St. 10 30. Name 31. Date filed (Month, Day, Year) FEB 2 7 20 32. Registrar's Signature State 2006 medi Registrar

		1	For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of Fertificate of			giene	6 05725
400	2	\$	Decedent's Name (First, Middle, I	Last)				2. Date of Dea Month	ith Day	3. Time of Death
	Physicia /Medic		AILEEN	HUNTE	ER				zrid z	
	Examin		4a. Facility Name (If not institution, g			4b. City, Town, o	or Location of Dea	th	4c. County	
		93	Genesis Brightwo			Tows		C O Date of Dies		imore
	Funeral Director		5. Social Security Number 410–34–3779	1. Sex 7. A 1 □ M 2 □ XF	nge (In yrs. last birthday 91 Yrs.	Months Days	Hours Min		, Year)	 Birthplace (State or Foreign Country) Kentucky
145	p ,		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or L	ocation				10d. Inside City Limits
	anyla shov	_				e River				1 ☐ Yes 2 🎇 No
	he M	ecto	Maryland Baltin	nore	MIGGI	10f. Zip Code			10g. Citizen of \	What Country?
	with the contract of the contr	ă	2113 Sunnythorn	Road		212	20		USA	
	ns 23	Funeral Director	11. Marital Status	12. Was Deceden	nt Ever in U.S. 13.	. Was Decedent of I	Hispanic Origin? (Specify Yes or No-	14. Rac	ce - American Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Itema 23a or 28e-f show or other treumatic event, the Madical Examinar must be notified a	by Fun	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces d 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	₹No	If Yes, specify Cub 1 ☐ Yes 2 💢 No	an, Mexican, Pue	no Hican, etc.)	Specif	ck, White, etc. y: White
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212	filed within Hygiene. Ither then "	E O	8 vears	College (1-40)		ervisor			Johns	Hopkins Hospital
덜	be filed htal Hygi od other event.	BeC	17. Father's Name (First, Middle, La	ist)				ame (First, Middle,	Maiden Suman	ne)
<u>Va</u>	should band Ments a marked	ဥ	William Greene					Goshen		
Maryland	2 should be and Mental Is marked of reumatic even	l i	19a. Informant's Name/Relationship			ling Address (Street				, State, Zip Code) MD。 21220
	s 1 and 2 of Health a Item 27 Is other tree	1	Lila Hunter 20a. Method of Disposition	Daughter	20b. Place of Disp		orn Road,	Date		- City or Town, State
סר	Pages 1 nent of H ont: If Ite ury or ot	113	1 X Burial 2 ☐ Cremation 3		cemetery, cri	ematory or other pla e Nationa		oruary		
Baltimore,	permit. Page Department Importent: I eny injury o		4 □Donation 5 □Other (Spe 21. Signature of Funeral Service Li	-		22. Name and Addre	ess of Facility Funeral	Home Of	Dundalk	ille, MD.
B	8918		233 Part Enter the disease office	Complications that caus	LUI/	7110 Soll	lers Poir	nt Road,	Dundalk	Approximate
		-	23a. Part 1. Enter the disease, of c shock, or heart failure. List or Immediate Cause (Final	nly one cause on each	line.	(= 0 = (200.10	80:11	1 17	Interval Between Onset and Death
2	Physician /Medical		disease or condition resulting in death)	a. Due to /or	CVA (CERE	SROUH	AZCI D	-0(7)	days
į,	Examiner			H C	PERTER	15,0N		nacio	EI	dans
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	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events		RONAR	Y ART	FRY	D 12 Ex-	17 F	dop
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9 ×	ding p	/Me	IF FEMALE:	23c. If yes, outcom	ne of pregnancy				23d Da	ate of delivery
Вох	death certificate e attending phys d for use as the	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	☐Ectopic pregnand	су			onth Day Year
o.	the y th	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
Ω.	law requires that as been signed b 2 should be deta	by PI	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause g	ven in Part I.	23e. Did t	obacco use con	tribute to the cause of death?
rd	w require been sig should b							. 10	Yes 2□No	3 Probably 4 Onknown
of Vital Records,	taw requas been 2 shoul	Completed						24a. Was	osv	Were autopsy findings available prior to completion of cause of
Œ —	The ete h page	ОП						perfo 1 ☐ Yes	rmed? 2 □ No	death? 1 Yes 2 No
/ita	Physician: 1 this certificer ral director, p	Be (25. Was case referred to medical examiner?					eath (Check only o	one)	
£	Physic this o	၉	1 Yes 2 No	Hospital: 1 Inpa		ent 3 DOA		Home 5 Resi		
	ling After Tune	lon	27. Manner of Death 1 □ Natural 5 □ Pending		njury 28b. Time Day Year) Injury	/ Wo	ork?]Yes 2 □ No	280. Describe	how injury occu	1160
Division	eatl or:	licat	2 Accident Investigation 3 Suicide 6 Could not determine	ot be 28e. Place of	Injury - At home, farm,			28f. Location (Street and Num	iber or Rural Route Number,
Οį	s after st Dire	Certification:	4 Homicide	building,	etc. (Specify)			City or To	wn, State)	
	To the Hospitel or Ati within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the be xaminer: On the basis and manner		ath occurred at the investigation, in my	time, date and pla opinion, death oc	ice, and due to the curred at the time,	cause(s) and m date and place	anner as stated. , and due to the cause(s)
	To the Within To the compl	₩	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date sign	ed (Month, Day, Year)
	(XI		> Snept	e MD		DOG	053150		FEB 3	23rd 2006
1,	1		30. Name and address of person w	no completed cause of	of death (Item 23a) (Typ	e, Print)		SU	INEIL	23rd 2006 0 ND 181A 21045
4	<u> </u>		SHAWUNNA	CA GUPZI	A 9650.	SANTIA	GORDA	1 (20 6014	13.A 21045
1	Sta Regist	ate rar	30. Name and address of person w Shawn A 31. Date filed (Month Page 797)	7 2006 32.	Istrar's Signature	gosse				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** DOROTHY MAMIE JOHNSON FEB. 22 2006 1:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2552 W. LOMBARD STREET BALTIMORE CITY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 243-16-8435 83 Director 01/18/1923 N. CAROLINA Usual Residence of Decedent with the Maryland 10c. City, Town or Location worle 10d. Inside City Limits ?? is marked other then "naturel", or iteme 23a or 28a-f eho: treumatic event, the Medical Examinar intert to incitified at MD N/A 1XYes 2 □ No Director BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2552 W. LOMBARD STREET or iteme 23a 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: BLACK 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry LEAVERMAN'S permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene importent: if flem 27 is marked other then any injury or other treumests. Elementary/Secondary (0-12) 1 2TH College (1-4or 5+) SEAMSTRESS CLOTHING COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN BROCKINGTON SUSANA BROCKINGTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDRA D. TAFT / DAUGHTER 2554 W. LOMBARD ST., BALTIMORE, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD_HETTERANS_CEM. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/02/06 CHELTENHAM, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Imeral Service Licensee 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD 0111 Enter the dispase, or complications that caused the death or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease of condition resulting in death) **Physician** OLON ASTATIO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760 The law requires that the death certificate be by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of deliver 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 ☐ Probably 4 ☐Unknown 1 Yes 2 No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. i Director: A d in by the fi 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funeral (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifier 016354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AV BALTIMURE MO NES 32, Registrar's Signature State Good ! Registrar

			1 - For State Registrar	State of Ma	-	epartment Certificate			Mental Hy	giene	A A A	05727
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Las ETHEL 4a. Facility Name (If not institution, give	street and number)				ocation of Dea	2. Date of De Honth	240	. County of Death	3. Time of Death
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	the Maryland 28a-f show	Director	10a. State HOWARD 10b. County HOWARD		10c. City, Town	IBIA	200			10- 0		10d. Inside City Limits 1 XYes 2 □ No
	3a or	i Dir	5210 HARPERS F	ARM ROAD		10f. Zip (044				tizen of What Cou ISA	intry?
980	hours after death with the Maryland tural', or Items 23a or 28a-f show Il Exerciter rough be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married ③☐ Widowed 4 ☐ Divorced	12. Was Decedent Examed Forces? 1 Yes YNG If Yes, Give Year or Dates:		13. Was Decede If Yes, speci		anic Origin? (Mexican, Pue Specify:	Specify Yes or Ne erto Rican, etc.)		14. Race - Amer Black, White	
21215-0036	within 72 ene. than "nai	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		- (Decedent's Usual Give kind of work life. DO NOT use HOUSEW	done duri retired)		orking		ind of Business/Ir	
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Maryland	Mer Mer arks	10	WILL SHERMAN 19a. Informant's Name/Relationship (T	ives (Brief)	105	Mailles Addiss	(64		E BETNE		. T O T	
	es 1 and 2 of Health a f itam 27 is r othar trai		ANNETTE J. BAKI 20a. Method of Disposition 1 Burial 2 Cremation 3	ER / DAUG	20b. Place of I cemetery	4026 B. Disposition (Name or other property)	RIGH' e of ner place)	T ROC	Date	20c. Lo	LLICOT :	CITY, MD
Baltimore,	permit. Pag Department Important: i any injury o		* 4 □ Donation 5 □ Other (Specify, 21. Signature Funeral Service Licens		www.	LEM CE 22. Name and 4600	Address o	4 m - 100	/03/06 OWELL F EIGHT A			GEORGIA ME 21207 MORE, MD
8760,	cate be executed by Secure and by Secure and prize and the burial-transit	lical Examiner	23a. Fert1. Enter the disease, or complication, heart failure. List only of immedia. Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a I CUTEN Due to (or as a Due to (or as a C. NEUM	consequence of	162010): NARY):	4774.5	PAT	HY		KF .	Approximate Interval Between Onset and Death
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٣	w requires that the s been signed by th should be detache	by	Part II. Other significant conditions co	ntributing to death but	not resulting in t	he underlying ca	use given ir	n Part I.				he cause of death?
Vital Records	The law ate has b page 2 sl	Completed									prior to co death?	opsy findings available impletion of cause of
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6			30. Name and address of person who c	ompleted cause of dea	ath (Item 23a) (T		ENN	ETT	FZE	H	ad	4
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			For 1 - State Registrar	State of M	aryland		artment of h		and Mental	Hygie Reg	Z111118	05729
	Physici /Medio	al		nnis Jon	es				2. Date of Month		Day Year 18 2004	
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Balti	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service Ronal d	S. Wade ir		Ba	iltimore,	MD 2	21201		altimore	
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O. Box 6	at the death certific by the attending p tached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal d	leath 3	Ectopic pregnancy	у			23d. Date of de Month	livery Day Year
ords, P	v requires that been signed b should be deta	ρλ	Part II. Other significant conditi	ons contributing to death b	ut not result	ing in the u	nderlying cause gru	ven in Part I.		Did tobaco		o the cause of death?
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State Registrar 31. Date filed (Month, Day, Year) FEB 2, 7 2006

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



111 PENN STREET, BALTIMORE, MARYLAND, 21201

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1 Natural 2 Accident 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30c. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30c. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30c. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30c. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30c. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30c. Name and address of person who completed cause of death (Item 23b) (Type, Print) 30c. Name and address of person who completed cause of death (Item 23b) (Type, Print) 30c. Name and address of person who completed cause of death (Item 23b) (Type, Print) 30c. Name and address of person who completed cause of death (Item 23b) (Type, Print) 30c. Name and address of person who completed cause of death (Item 23b) (Type, Print) 30c. Name and address of person who completed cause of death (Item 23b) (Type, Print) 30c. Name and address of person who completed cause of death (Item 25a) (Type, Print) 30c. Name and address of person who completed cause of death (Item 25a) (Type, Print) 30c. Name and address of person who completed cause of death (Item 25a) (Type, Print) 30c. Name and address of person who completed cause of death (Item 25a) (Type, Print) 30c. Name and address of person who completed cause of death (Item 25a) (Type, Print) 30c. Name and address of person who completed cause of death (Item 25a) (Type, Print) 30c. Name and address of person who completed	>	S S			lospital: 1 🗆 Inpatie	ent 2 🔀 I	ER/Outpatier	nt 3□ DC	Oth Oth	er: 4 □ N	ursing Hom	ne 5 🗆 Res	idence	6 □Other (Spe	cify)
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			State of Maryland / Department of Health and I State Registrer For State of Maryland / Department of Health and I Certificate of Death		iene g. No.	05732
	Dhusiai		Decedent's Name (First, Middle, Last)	2. Date of Death	h Day Year	3. Time of Death
	Physicia /Medic	_	William Mathias Kricker	rebruch	423 2006	21.55m
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
	<u> </u>		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Funeral Director		215-05-7641 1XIM 2 F 97 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, May 9,	Year) Con	yland
			Usual Residence of Decedent			
	arylar show	-	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	he M.	Director	MD Baltimore Catonsville	14/	Og. Citizen of What Co	
	with t		10e. Street and Number 715 Maiden Choice Lane HV 302 21228		USA	muy:
	death ms 23	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Amer	
စ္	or its	Fur	Armed Forces? If Yes, specify Cuban, Mexican, Puert 1 □ Never Married 2 □ Married 1 □ Yes, 2 □ No 1 □ Yes 2 □ No Specify:	to Hican, etc.)	Black, White	, etc. hite
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7	n 72 h	iete	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	rking	16b. Kind of Business/l	ndustry
12	l withi lene. r then	Completed	Elementary/Secondary (0·12) College (1-4or 5+) 4 Colone1		U.S. Gover	nment
פַ	e filed Il Hyg oths	ВеС	17. Father's Name (First, Middle, Last) 18. Mother's Name	me (First, Middle, M	Maiden Surname)	
/lar	Menta Menta arked	ToE	William Edward Kricker Kather	rine Adam	.S	
Mar	2 sho	N I	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru Frank McNutt Kricker - Son 1005 Hogtown Road Han			ip Code)
e e	1 and Health em 27 ther t		Frank McNutt Kricker - Son 1005 Hogtown Road; Han 20a. Method of Disposition (Name of		DE 19952 20c. Location - City or 1	own. State
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If them 27 is marked other than "natural", or itema 23e or 28e-f show any injury or other treumatic event, the Madical Examinar must be notified at once.	l	4 □ Donation 5 □ Other (Specify) Metro Crematory 2-25 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility Ste	erling-As	Baltimore, hton-Schwa	
ä	Depa Impo eny ii		21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Stervice Funeral Home of Ca 1630 Edmondson Ave	atonsvill enue: Cat	e, Inc.	MD 21228
•	7		23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	c or respiratory arre	est,	Approximate Interval Between
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~ ×	ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deli	, oo
Bo		Physician/Med	23b. Was decedent pregnant in the past 12 months? 1		Month	Day Year
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	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificete has completely filled in by the funeral director. page 2.	Medical	29a. Certifier (Check only one) e, and due to the ca urred at the time, da	ause(s) and manner as ate and place, and due	stated, to the cause(s)	
	Fo the	Me	29b. Signature and title of certifier 29c. License number		9d. Date signed (Monti	
	1/\		▶ Edara Mara, M.A. DO05-60	192 /	chruary ?	23, 7006
	20x,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edana Mann 900 Caron Avenue 3	2		/
	g.		Edding mann 900 Coton Avenue is	altmore	manylan	d 21779.
	- Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 2 7 2006			
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		•	1 - For State Registrar	State of Ma	aryland		rtment of H tificate of I		Mental Hy	giene Reg. No. 0	6	05733
	«Dhuniai	3	1. Decedent's Name (First, Middle, Last						2. Date of De		Year	3. Time of Death
	Physici /Medic		Mary C.	LaRos	3a				Februa	ry 24, 2	2006	3 :30 a ^M
6	Examin	er	4a. Facility Name (If not institution, give Pickersgill	street and number)			4b. City, Town, or		ath	4c. County	of Death altimo	ore
	. Funeral Director			х] м 2 Д F	97 (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th 19, Year) 1909	Coun	lace (State or Foreign try) /land
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation				1	0d. Inside City Limits
	Maryl -f sho ie J	ţ	MD Balt	imore		Towso	חכ					1 ☐ Yes 21 No
	r 28a	Director	10e. Street and Number		1		10f. Zip Code			10g. Citizen of V	What Coun	try?
	th with	a D	615 Chestnut Av	enue			2	1204		U.	S.A.	
	ams	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		i. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (In, Mexican, Pue	Specify Yes or Norto Rican, etc.)	o- 14. Rac	e - Americ	
920	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "natural", or Itams 23c or 28a-f show event, the Medical Exattribet mult be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:		-	□Yes 2□No	Specify:	,	Specify	V*	nite
2-0	72 ho	sted	15. Decedent's Edi (Specify only highest grad				ent's Usual Occup		orkina	16b. Kind of B	usiness/Ind	dustry
21	within 7 ene. than "c	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	erical	i)	orking	041	Come	
2	e filed within al Hygiene. i othar than vant, the we		17. Father's Name (First, Middle, Last)			0.10	11001	18 Mother's Na	ame (First, Middle		. Comp	Jaily
/lan	2 should be and Mental Is marked o	To Be	James	Corrig	an				rolyn		1	hart
Maryland 21215-0036	nd 2 sho lith and I 27 is me r traume		19a. Informant's Name/Relationship (7) Edward J. McDonou		ı		g Address (Street aney Ct.,			ner, City or Town, 21787	State, Zip	Code)
Jre,	of Hee of Hee itam otha	13	20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name of place)	e)	Date	20c. Location -	City or To	wn, State
imo	Pages nent of h ant: If its ury or of		1 🔀 Burial 2 □ Cremation 3 □ 1 □ Cremation 3 □ Other (Specify)			anéy V		2/28	3/06	Timoni	um, M	1D
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumetic erones.		21. Signature of Funeral Service Licens	⇔ William	G. D		Name and Address					ome, Inc.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause on each li	d the death.	Do not ente	er the mode of dyin	g, such as cardi	ac or respiratory a	ırrest,		Approximate Interval Between
V	Physician	8 1	Immediate Cause (Final disease or condition	200		25500	re De	inent,	A			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as								0
	LXaiiiiici	- L	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a conseque	ence of):						
d	uted s insit	Examiner	cause (Disease or injury that initiated events			31100 017.						
0,	cate be executed physician and the burial-transit	Еха	resulting in death) Last	Due to (or as	a conseque	ence of):						
8760,	cate be physicia the bu	Ical		d								
9		Med	IF FEMALE:		,							
Вох	The law requires that the death certific te has been signed by the attending f page 2 should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth 4□Pregnant a	2 Fetal	death 3	Ectopic pregnancy Other (specify)				te of delive onth	ry Day Year
o.	that the de ed by the a detached t	ıysic	1 □ Yes 2 No 9 □ Unknown	9□ Unknown	t time of dea	aun 5	Otner (specify)					
S, P	s that ned b e deta	by PI	Part II. Other significant conditions co	ntributing to death b	,		1			tobacco use cont	tribute to th	e cause of death?
rds	w requires been sign should be		coronary A	vitery o	ise	A se	9240	soporo	S 10	Yes 2 No	3 ☐ Prob	ably 4 Unknown
Vital Record	e law requ has been ge 2 shoul	ompleted							24a. Was			psy findings available npletion of cause of
E E		Con							perf	ormed?	death? 1 🗌 Yes	
Vita	Physician: This certificatal director, p	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or -	eath (Check only			
of	Phys this ral dii	-: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie		R/Outpatient 28b. Time of		4 Sursing	Home 5 ☐ Res	idence 6 Oth		′)
on	Attanding I r death. ector: After by the funer	tlor	1 VNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	28c. Injur Wor M 1 🗆	k? Yes 2□No		,,		
Division	after death after death Director: d in by the	ertification;	3 Suicide 6 Could not be determined	289. Place of In	jury - At hon tc. (Specify)	ne, farm, stre	eet, factory, office			(Street and Numb wn, State)	er or Rura	l Route Number,
	ital or rs afte al Dire	Cerl		Dallaling, 60					Ony or ro			
	To the Hospital or within 24 hours after To the Funaral Director Completely filled in the Funaral Completely filled in the Funara Completel	ledical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best iner: On the basis o and manner st	of examination	on and/or inv	estigation, in my o	pinion, death oc	curred at the time	date and place	and due to	the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and tale of certifier	1	А		29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
	,		Ill Antho	7 Ku	Ky	, and	100	5205		Febru	my	24,2006
	5		30. Name and address of person who o	ompleted cause of c	de em :	23a) (Type, I	harles!	St. Ba	lts. Mc	1 5,3	205	Oay, Year) 24, 2006
	° Sta	te	31. Date filed (Month Day Year)	32. Registr	rar's Signatu	159	P N -					
1	Registi	1 100	FEB 2 / 2	UUb X	How &	To figure						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day ZJ **Physician** Margaret Barbara Laur 200 ebrown /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Madical C7 Boltimore in Mone my nit If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 22, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XX 218-03-6426 87 Yrs. 1918 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir then "natural", or iteme 23a or 28e-f ehow the Medical Examiner must be notified at 1 ⊋Yes 2 ☐ No MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4408 Leeds Ave 21229 U.S.A. Pages 1 and 2 should be filed within 72 hours after death valent of Health and Mental Hygiene.

and: If Item 27 is marked other than "ratural", or Iteme 23 and 19 to other freunatic event, it a Medical Examinational muta Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ₹25No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank J. Laur Sophia Flather ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadette Bender/Niece 595 Manor Rd Severna Park 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 2-27-2006 permit. Page Department of Important: if any injury or once. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Ambrose Funeral Home, In 1328 Sulphur Spring Rd. 21. Signature of Funeral Ser Inc. Arbutus MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final DVO **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DNOW Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed V that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box (IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) P.O. this certificate has been signed by the rail director, page 2 should be detached 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ZONo Certification: To 1 Suppatient 2 ☐ ER/Outpatient 3 ☐ DOA After the 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a. Certifier TScrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

completely

State Registrar

31. Date filed (Month,

0

(Check only one)

29b. Signature and tale of certifier

V

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Menth, Day, Year)

		•	For State Registrar	State of Marylan		rtment of Hea tificate of De			ene 006	05735
7.7	Physicia /Medic		Decedent's Name (First, Middle, Last)	Long	ナレ		2.	Date of Death Month	Day Year	3. Time of Death
	Examin	er -	ta. Facility Name (If not institution, give to 6680 Pirch Way	street and number)		4b. City, Town, or Loc Elkridge		/	4c. County of Dea Howard	th
346.	Funeral Director			7. Age (In yrs. 59	last birthday) Yrs.		Under 24 Hrs. 8. ours Min.	Date of Birth (Month, Day, Y 01/06/1	ear) C	thplace (State or Foreign ountry) timore, MD
	Maryland f ehow		Usual Residence of Decedent 10a. State 10b. County MD Howard		y, Town or Loo ridge	cation				10d. Inside City Limits 1 ☐ Yes 2X No
	after deeth with the Maryland or Iteme 23a or 28a-f ehow or Iteme 20a or 28a-f ehow	Funeral Director	10e. Street and Number 6680 Pirch Way			10f. Zip Code 21075		100	g. Citizen of What C	•
36	urs after deet II', or Iteme 2 xeralise mu	by Funera	11. Marital Status 1 □ Never Married 2(五Married 3 □ Widowed 4 □ Divorced	12, Was Decedent Ever in U. Armed Forces? 1 Tyyes 2 □ No If Yes, Give Year or Dates: 1966—	1	Vas Decedent of Hispar f Yes, specify Cuban, M □ Yes 2 \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	nic Origin? (Specif lexican, Puerto Ric pecify:	y Yes or No- can, etc.)	14. Race - Am Black, Whi	te, etc.
21215-0036	d within 72 hours after giene. r than "natural", or Ite the Medical Exerctive	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Deced	lent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of working	D	epartment	of Parks
land 2	ted tygi her nt.	To Be Co	17. Father's Name (First, Middle, Last) John Long Sr				Mother's Name (F	First, Middle, Ma		
Maryland	es 1 and 2 should be fi of Health and Mental F f Item 27 is marked ot r other traumatic ever	-	19a. Informant's Name/Relationship (Ty Sallie May Long /			g Address (Street and Pirch Way,			•	Zip Code)
Baltimore,	permit. Pages 1 a Department of He- Important: If item eny injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	emoval from State	emetery, cren	sition (Name of natory or other place) ematory	02/27/		oc. Location - City or atonsvill	
Balt	Departr Departr Importa eny inju		21. Signature of Funeral Service Licens	MO1378	Gar 725	Name and Address of Y. L. Kaufman O Washington,	Facility Funeral Ho , Blvd, Elk	me at Mea ridge, M	edowridge Me 0 21075	morial Park, IN
	Physician /Medical Examiner		23a. Cant1. Enter the disease, of complete shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat le cause on each line. Due to (or as a conseq	sclan	er the mode of dying, so Le heer	ach as cardiac or r	espiratory arres		Approximate Interval Between Onset and Death
8760,	rate be executed shysician and the burial-transit	dical Examiner	S quential, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq Due to (or as a conseq						
Box 6	ne death certific the attending p thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
ds, P.O.	uires that the signed by Id be detacted	Þ	Part II. Other significant conditions con	ntributing to death but not res	ulting in the pr	nderlying cause given in	Part I.	23e. Did toba	·	o the cause of death?
Division of Vital Records,	The law requir ate has been si page 2 should	Completed		J				24a. Was an autopsy perform	prior to	
f Vita	Physician: This certificated at director, p	To Be (25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	Other	. Place of Death (6) ice 6 □Other (Sp	ecify)
sion o	Attending Ph death. ctor: After th y the funeral	Certification:	27. Manner of Death 1 Asiatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work? M 1 ☐ Yes	2 🗆 No		v injury occurred	
Divi	oitel or At urs after d orel Direct		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	(y)			City or Town,		
	To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: All completely filled in by the fu	Medicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami 29b. Signature and tille of certifier	sician: To the best of my knoner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my opinio	on, death occurred	at the time, dat	le and place, and du	e to the cause(s)
	wit Too		I the fl	my		0 Y	7137	F	ehury,	24,2006
	(e Sta	10	30. Name and address of person who con the Manual M	Dimpleted cau of death (Iter Note: 1	n 23a) (Type, Chu ature	ed al le	nbimi	, nd 210	061	
	Regist	100	FEB 2 7 2	All I	B. F.	barks				

DHMH 17 Rev 1/2001

ORIGINAL

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Phys /Me	ician dical	1. Deceder		(First, Middle,		le	pez						2. Date of De Month Februa	Day	Year 2006	3. Time o	of Death 20 PM
	niner		artla	not institution, and of I	Hyatt 6. Sex	svil	1e	rs. last birthday	Нуа	ttsv 1 Year	ille If Under		8. Date of Bir (Month, Da	Prin	ce Geo	rge's	
Direct	or	124- Usual Res 10a. State			1 □ M	2 ∏ F	81	Yrs. City, Town or I		Days	Hours	Willi.	Apr 21	1924		10d. Inside (unk City Limits
ith the Mary or 28a-f sh	Director	MD 10e. Stree			e Geo	rge'	s T	emple 1	Hills 10f.Zip		0748			10g. Citizen US.	of What Cou		s 2√No
DESILITIOTE, INITION AND ALLE 13-00000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment: If item 27 is marked other than "naturel", or Items 23e or 28a-f show eny injury or other traumatic event, the Mudical Experiment is the confilled at	by Funeral	11. Marital	l Status ever Marri	1 Lane ed 2□ Marri	ed	Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	2∏ No ve	n U.S. 13	. Was Dece If Yes, spe	dent of H cify Cuba			ecify Yes or No Rican, etc.))- 14.	Race - Ameri Black, White, ecify: bla	etc.	
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id be filed w lental Hygier ked other th	To Be Cor	17. Father	's Name (First, Middle, I	unk Last)					unk	18. Moth	er's Nam	e (First, Middle	, Maiden Sur	name)		unk
things in the state of the stat		19a. Infor	art1	ame/Relationsh and of				65	500 ri	ggs		Hyat	al Route Numb tsville	e, MD	wn, State, Zi 20783 on - City or T		
SAITIMORE, permit. Pages 1 ar Department of Hea Importent: If item eny injury or othe		`4□□	Burial 2 (Donation	□ Cremation 5 🎇 Other (Sp	pecify) i	n st	State	b. Place of Dis cemetery, cr	ematory or	other plac							
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D. BOX to be death certiful the attending the attending the attending to use a	n/Me	IF FEMAI 23b. Was in th 1 □ 9 □		⊒ ₩6	23c.	1 Live	utcome of prebirth 2 Finant at time	etal death	3 ⊟Ectopic p 5 ⊟ Other (s					23d	. Date of dein Month	very Day	Year
COTGS, P.C. w requires that it been signed by should be detac	2	Part II. Ot	her signi				death but not ENS(resulting in the	underlying	cause giv	en in Part	l.		tobacco use		the cause of	
	amo					ER	CIPI	DEM	104				1 ☐ Yes	opsy ormed? 2 No	death?	topsy finding ompletion of 2 No	s available cause of
Phy Place	F	exam	iner?		Hos	1 ∟ 28a. Date	of Injury	2 ER/Outpat	of	OA Ott	v at	_	th <i>Check onl</i> ome 5 Res 28d. Describe	sidence 6		erfy)	
DIVISION OI I or Attending Phy after death. Director: After thi	1	3 S 4 H	latural Accident Suicide Homicide	5 Pendin investi 6 Could determ	gation not be	28e. Plac	nth, Day Yea se of Injury - A ding, etc. (Sp	At home, farm,	М	1 🗆	Yes 2]No	28f. Location City or To	(Street and Nown, State)	lumber or Ru	ral Route Nu	umber,
Hospite Hospite Funerel	od leal po		eck only	Cartifyir 2 Madical	ng Physici Examiner	: On the	ne best of my basis of exar nner stated.	knowledge, de nination and/or	eath occurre investigation	d at the ti n, in my o	me, date a opinion, de	nd place ath occu	and due to the	e cause(s) an e, date and pla	d manner as ace, and due	stated. to the cause	ə(s)
To the within 2	N N			title of certifie	£	lece		М	D 25		se number	583	190	29d. Date s	a OE	n, Day, Year)
Reg	State gistra	50 Ω 31. Date	LEST	tKUND nth, Day, Year)	on a	32.	use of death ATIL Registrar's S	Ret	pa, Print)	EEN	0 <u>0</u> 2	RY		410113	SVILLO	E WO	, 20781

			For State Registrar	of Maryl		artment of rtificate of	Health and N Death		ene 1. N2 0 0 6	05737
		7	Decedent's Name (First, Middle, Last)	-				2. Date of Death	Day Year	3. Time of Death
	Physici /Medic			lcGeady				February		2:55 а м
1.	Examin	er	4a. Facility Name (If not institution, give street and 4 Hardy Court	number)		4b. City, Town,	or Location of Death		4c. County of Deal	
	Funeral		5. Social Security Number 6. Sex		yrs. /ast birthday)	If Under 1 Year		8. Date of Birth		hplace (State or Foreign
4	Director		217-20-2717 1× M 2 I	79	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	1926 Ma	ryland
	and w		Usuaf Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	cation				10d. fnside City Limits
	Mary -f sh	tor	Md. Baltimore	T	owson					1 ☐ Yes 2X No
	or 28e	Director	10e. Street and Number	1.		10f. Zip Code		100	g. Citizen of What Co	
	ath wi	rai	4 Hardy Court				204			USA
36	be illed within 72 hours after death with the Maryland ital Hygiene. Id other than "neturel", or Items 23e or 28e-f show event, the Medical Examinational te nutilised.	by Funeral	1 Never Married 2 Married 1 7 Yes,	ecedent Ever Forces? s 2 No Give r Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	Decity Yes or No- Dican, etc.)	14. Race - Ame Black, Whit Specify:	
2-0	72 hou		15. Decedent's Education (Specify only highest grade complete	id)	16a. Dece	dent's Usual Occu	ipation during most of work	kina 16	3b. Kind of Business	Industry
21	ne. han "	Completed		(1-4or 5+)	life.	DO NOT use retir	9 <i>d)</i>	(Alig		
d 21	e filed within al Hygiene. I other than '		17. Father's Name (First, Middle, Last)	+4	FTE	ctrical	Engineer 18. Mother's Nam	ne (First, Middle, Ma	Engineeri aiden Sumame)	ng
lan	should be filed vand Mental Hygies marked other tumatic event, In	To Be	Patrick R. McGeady					McDonough		
Baltimore, Maryland 21215-0036	ges 1 and 2 should be t of Health and Mental if Item 27 is marked or or other treumatic eve		19a. Informant's Name/Relationship (Type, Print) Mrs. Margaret McGeady/	ral Route Number, (ld. 21204	City or Town, State, .	Zip Code)				
ore,	of Her		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal fro		b. Place of Dispo cemetery, crei	osition (Name of matory or other pl	ace)	Date 20	c. Location - City or	Town, State
Ę	nit. Pag vartment ortant: I injury c		4 □Donation 5 □ Other (Specify)	H	lilltop 9				Towson, M	d.
Bal	permit. Pages 1 and 2 Department of Health e Important: If Item 27 li eny injury or other tre		21. Signature of Funeral/Service Licenside	_		1050 \	owson Fur ork Rd. T	owson, Mc	1. 21204	
1			23a. Part . Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the n each lin	death. Do not en	er the mode of dy	ing, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
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	requires that been signed b	y Pt	Part II. Other significant conditions contributing t	death but no	t resulting in the u	nderlying cause g	iven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
g	w require been signated should b							1 ☐ Yes	2 □ No 374	obably 4 Unknown
Division of Vital Records,	The law ate has b page 2 s	Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			10		th Check only one		
o	Phys r this ral dir	. To	1 105 2/2010	Inpatient	2 ER/Outpatier	IL SELDON	ther: 4 Nursing H	ome 5 Residen 28d. Describe how	ce 6 Other (Spe	cify)
lon	Attending ir death. ector: After by the fune	ation	Natural 5 Pending (A 2 Accident investigation	lonth, Day Yea	ir) Injury	W	ork? ⊒Yes 2 ⊒No		,,	
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	oftel or urs afte orel Dir	O								
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medicai		the best of my basis of examination stated.	r knowledge, deat mination and/or in	vestigation, in my	opinion, death occu	rred at the time, dat	e and place, and du	to the cause(s)
	To viti	Y	29b. Signature and title of certifier Paul llavy	110			16587		Feb. Z	
	1241		30. Name and address of person who completed of Paul Chang, me	750	5 056	er Derve		5302,	Towson,	2,2006 MD 21264
X	Sta Registr		S1. Date filed (Month, Day, Year) FEB 2 7 2006	. Registrar's S	Signature	(ask)	ŧ	,		/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Macciola, Jr. Premen Edward 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPIT 5. Social Security Number 59 110re -1m 01 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2 □ F 76 214-26-0247 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, Ite Medical Evatur roust be notified at 1 ☐ Yes 2 X No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37 Fountain Ridge Circle 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White. Specify: 2 3. Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 and Mental Hygiene.
7 is marked other than "n Teledyne Energy Elementary/Secondary (0-12)
12th Grade College (1-4or 5+) Lab Technician Sustems 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Premen Edward Macciola, Sr. Rebecca Condell. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and z timent of Health a Edward Macciola P.O. Box 1875, Ocean City, MD injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/27/06 Bayview Crematory Baltimore, Maryland *4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes Buran a. 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ibrothola /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit the death certificate be execu Due to (or as a consequence of): Box 68760, attending physician Physician/Medical nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No of Vital Records, P.O. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. β 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 Yes 2 No Ma uts funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Despatient Other: 4 Nursing Home 1 Yes 2 No Certification; To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one ro the 29b. Signature and title of certifier

State Registrar 30. Name and address of person whe

Day,

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reprive Bo

completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

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Amend Item #Stateon Whitelede DEFERTHENGS 5 2162/162/1664 Attal Hygiene 1- State mend ITem #2 Per Dvr G852 2/270 Odificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2006 v 22,1006 **Physician** February Miller Nancy 3:07A M /Medical 4a Escility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7 Beechfield Avenue Elkridge Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M XXF Director 220-38-3235 64 Yrs. Feb. 15,1942 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f show r than "netural", or items 23a or 28a-f ehov the Medical Examinar must be notified at 1 □Yes 2√2 No Director MD Howard Elkridge 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6372 6327 Beechfield Avenue 21075 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. hours after 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White 5 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H Walter Raleigh Agnes R. Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 80 Pages 1 end 2 ment of Health a ent: If Item 27 is Sharon Twigg (Daughter) 5517 Fox Tail Lane Ellicott City, MD 21043 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Importent: If any injury or once. Meadowridge Memorial Park 2/25/06 Elkridge, Maryland 21. Sign June 15 Ineral Service Licensee Gary L. Knufman Funeral Home at MMP. Inc 7250 Washington Blvd. Elkridge, MD 21075 and rart1. Enter the dis.—se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic cancer months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to intrinsical cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical as ettending IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1□ Yes 2□No funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospitaf: 1 Inpatient 2 ER/Outpatient 3 DOA 2 Other: 4 Nursing Home 1 Yes 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: Aftert 28b. Time of 28c, fnjury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident To the Hospins, — within 24 hours after death.

To the Funerel Director: Aft 5 Pending 1 ☐Yes 2 ☐No investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1 Centra Feb 23, 2006 D0062545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kendra Kay, MD 5755 Cedar Lane Columbia, MD 21044 31. Date filed (Month, Day, Year) State 2006 Registrar

			For	State of Maryla				lental Hygie	ene	00010
			State Registrar		Ce	rtificate of L	Death		No.UUD	U5/4U
	Physicia		1. Decedent's Name (First, Middle, L	Mathis				2. Date of Death Month	Day Year	
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or	Location of Death		4. County of Dea	
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	Funeral		Social Security Number. 6.	Sex 7. Age (In yr	s. last girthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Bii	rthplace (State or Foreign ountry)
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	D .		Usual Residence of Decedent 10a. State 10b. County	100	City. Town or Lo	oation				10d. Inside City Limits
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	4 within 72 hours after death with the Maryland jiene. Than "natural; or Items 23a or 28a-f show Itte Madical Exalt Text must be rediffed at	듬	10e. Street and Number	- 41 -		10f. Zip Code		109	, Citizen of What C	ountry ?
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			30. Name and address of person wh	o completed dause of death (I	tem 23a) (Type,	Print)	- Ban -	too 1	Cal	1111 21326
			31. Date filed (Month, Day, Year)	35 Registrar's Sir	mature 15	NOCZHIA	المال الراء الل	+507 13cc	Bourgae	2006 MD 21229
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	Funeral		5. Social Security Number 6. Sex 15	M 2 F 7. Age (In yrs. last birtho	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea - 8- 94	(r) Cot	place (State or Foreign intry)
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of Vital	ician: Th certificate rector, pag	O	25. Was case referred to medical	100	-	26. Place of Death	1 Yes 2 7	vo 1 ☐ Yes	2 LI No
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on	th. After funera	ţ	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Inju		? ′es 2 □ No			
is.	dea ctor y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm	street, factory, office	2	8f. Location (Street	and Number or Rui	al Route Number
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_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 y Certifying Phys	lician. To the best of my knowledge 3	anth opcurred at the two	e ditta find plane is	nd due to the ease-	et and one or serv	rtalised
	24 h	edical	(Check only 2 Medical Examinone)	er: On the basis of examination and/o and manner stated.	r investigation, in my opi	inion, death occurre	d at the time, date a	nd place, and due	to the cause(s)
	o the o the omple	Me	29b. Signature and title of certifier		29c. License	number	29d. [Date signed (Month	Day, Year)
	⊢ ≯ ⊢ ŏ		1 Stranger	M.D.		58770			
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			30. Name and address of person who con			α	Mar 1	1 70077	
. Psy	S. 49. A.		Jeremy Graf 31. Date filed (Month, Day, Year)	32. Registrar's Signature	nilip Drive	Ulney	Figry Kin	9 50824	
	Sta Registr		FEB 2 7 2006	SE. Higgistral a Signature	6° a				
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			For State Registrar	State of Mary	-	artment rtificate			nd Me	-	giene	41116	0574	2
	Physici	20	1. Decedent's Name (First, Middle, Las	st)						2. Date of De _Month	ath Da	y Year	3. Time of Dea	th
	/Medic		Joseph Anthony							Februa	ry 2	Ž4, 2ÖÖ6	1:30AM	М.
	Examin	er	4a. Facility Name (If not institution, give				rown, or oodla	Location of	Death			County of Deat		
	F		Augsburg Luthera 5. Social Security Number 6. S		yrs. last birthday)	If Under		If Under 2	24 Hrs. 8	B. Date of Bir	th.	0.00		reign
	Funeral Director			X M 2□ F	88 Yrs.	Months	Days	Hours	Min.	March March	13,	1917 Mar	nplace (State or Fountry) y I and	
	how		10a. State 10b. County	100	. City, Town or Lo	ocation							10d. Inside City Li	
	Ba-f-	cto	MD Baltimor	`e	Baltim					——т			1 Tes 2	KNO
	3a or 2	Funeral Director	10e. Street and Number 1709 Summit Aver	nue		10f. Zip	Code 1237				_	tizen of What Co	untry?	
	deeth	nera	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Deced	lent of Hi	spanic Orig	in? (Spec	ify Yes or No)-	14. Race - Ame Black, White		
980	within 72 hours after deeth with the Maryland ene. then "neturel", or Iteme 23e or 28es-fehow he Madical Exertinet fauet be motified at	by Fu	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 (X) Yes 2 □ No If Yes, Give Year or Dates: WW		1 ☐ Yes 2		Specity:	, , , , , , , , , , , , , , , , , , , ,				hite	
2-0	72 ho	Completed by	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Dece	dent's Usua kind of wor	I Occupa	ition luring most	of working	g	16b. K	(ind of Business/	Industry	
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22	filed with Hygiene. other that		17. Father's Name (First, Middle, Last)			Engine	eer	18 Mothe	r's Name	(First, Middle	1		iai Tiles	—
land	should be file nd Mental Hy marked oth umatic event	To Be	Walter Olszewsk					Mar		achow				
Maryland 21215-0036	d 2 :		19a. Informant's Name/Relationship (Eileen Arnold-									or Town, State, 2 ore, Mary	Zip Code) /land 212	36
	s 1 and Healt Healt Item 2		20a. Method of Disposition		Db. Place of Disponentery, cre				Da			ocation - City or		
Baltimore,	permit. Pages Depertment of f Important: If It eny injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification)						2/27/	06	Ra	ltimore	, Marylan	Ч
alti	permit. Page Depertment o Important: If any injury or once.		21. Signature of Funeral Service Licer	Heather	Cain 2	2. Name and	d Addres	s of Facility	/ Leo	nard J	. Ru	ick, Inc	, riai y raii	<u>u</u>
ä	Depe Impo		1 Cent	is Can	-	305 H	arfo	rd Ro				laryland		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause of each line. a	DER (ANC	~	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Betweel Onset and Deat	
1760,	ite be executed iysicien and ne burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cool c. Due to (or as a cool d.										
.O. Box 68	The law requires that the death certificate be executed the has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pro						23d. Date of del Month	ivery Day Year	
Δ,	ires that signed b d be deta	by	Part II. Other significant conditions of	ANCER	t resulting in the t	underlying ca	ause give	en in Part I.			tobacco Yes 2		the cause of death	/
Ö	v requii been s should	ete	Capaziana A	DIPPO	118BASE	2				24a. Was	an	24h Were au	itonsy findings avai	lable
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tal		0	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only	2⊠No one)	0 10 165	261No	
of Vital	Physiclen: this certific ral director.	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	ent 3 DO	Othe	ac /				6 ☐Other (Spe	cify)	
0	ding Ph h. Atter th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time (of 2	8c. Injury Work	at c?	2	8d. Describe	how inju	iry occurred		
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not b	e 28e. Place of Injury -	At home, farm, si	M treet, factory		Yes 2 □ I		8f. Location	Street a	nd Number or R	ural Route Number,	
Δ	s after al Direction by	Cert	4 Homicide	building, etc. (S	респу)					City or To	evii, Siai	o/		
	To the Hospitel or Attent within 24 hours after deati To the Funeral Director: completely filled in by the	Medical	29a. Certifier Check only one) Certifying Pt 2 Medical Example 1	niner: On the best of manner: On the basis of exa and manner stated.	y knowledge, dea mination and/or i	th occurred nvestigation,	at the tim , in my or	ne, date an pinion, dea	d place, a th occurre	nd due to the d at the time	cause(s	s) and manner as nd place, and due	s stated. to the cause(s)	
	within To the comple	Me	29b. Signature and title of certifier			290	. License	nu <i>m</i> ber	_		29d. Da	ate signed (Mont	h, Day, Year)	
	-	+	Jaeneen	Halel	an'		De	385°	35		9	124/0,	}	
1	21		30 Name and address of person who	completed cause of death	(Item 23a) (Type	, Print)	00.	11	1.1		Δ	- 2	0.21	1 1
			1 TTS NEEM L	1+101/7711	122	011	The	2 17	214	1773	1	it 12	HEID IL	u)
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's	orgnature A.	0 M =							cap 28	

Amend item#26,pen*D, 852,2/2//06 II Black Indelible Ink. Ensure All Copies Are Legible. 2:2/2//06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** Overhulser 3:25 AM Chester Homer Feb. 2006 /Medical 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 2918 Cedarcrest Avenue Baltimore Co. Edgemere
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 N 2 □ F Yrs. Director Oct. 21,1920 Virginia 227-16-1553 25 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County rthen "natural", or items 23s or 28s-f ehow the Medical Examiner must be cutified at 1 ☐ Yes 2∕ONo Director Maryland Baltimore Edgemere 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2918 Cedarcrest Ave. 21219 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ⊠Yes 2 ⊋No If Yes, Give Year or Dates: 1945-47 filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 5 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Railroad 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) in and Mental E Be 8 mit. Pages 1 end 2 should be pertment of Health and Menta purtent: If item 27 is marked y injury or other traumatic so Vernie Lee Bayne Augusta L. Overhulser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2918 Cedarcrest Ave. Edgemere, Maryland Mrs. Marion L. Overhulser Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 2/25/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit.
Depertr
Imports
any inju 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 780 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Years **Physician** oronam α /Medical Due to (or as a consequence of): Examiner NO INIU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 Tilnknown نه 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown been si Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No s certificete hes bilinector, page 2 si 1 Yes 2 No Division of Vital After this certification, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 1 ☐ Yes 2 XNo ဥ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 Tes 2 No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 6 within 24 hours aft To the Funeral Di completely filled in To the Hospital 1 Contifying Physician: To the best of my knowledge, death consense at the time, date and place and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 00289 06 30. Name and address of person who completed these of death (Item 23a) (Type, Print) Panayiotis Baltatzis, M.D. 8113 Harford Road Suite 100 Parkville, MD 21234

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

2006

			For State Registrar	State of Maryland		rtment of H			ene g. No. 0 (16	157	L, L,
E	Physicia	an	1. Decedent's Name (First, Middle, Last)		D	A		2. Date of Death Month	Day .	Year	3. Time of	
	/Medic	al	MARK		17	ARHAM	Location of Death	February	24 40 COUNT	2006 by of Death	4	→ MM
į.	Examin	er	4a. Facility Name (If not institution, give sti The Johns Hophine	, Hospital		Baltim If Under 1 Year	0.1	Y Date of Birth	40. 000111	N/A	(C)	- Fai
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. I		Months Days	Hours Min.	8 Date of Birth (Month, Day, 05/04/	1953	Ouni NEW		_
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation				10	d. Inside Cit	ty Limits
	Maryla I-f eho	tor	MD N/A			ORE CIT	Y				1 XYes	
	death with the Maryland me 23a or 28a-f ehow	al Director	10e. Street and Number 2412 E. LAFAYE	TTE AVENUE		10f. Zip Code 2121	3	10	g. Citizen of USA	What Coun	ry?	
936	after or Ite	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Bi	ace - America ack, White, e ify: BLA	itc.	
1215-0036	72 hours "natural", dicel Exi	eted	15. Decedent's Educa (Specify only highest grade	ation completed)	(Give i	ent's Usual Occupa	luring most of work	king	6b. Kind of I	Business/Ind	ustry	
רצרי	within ene. than	Completed	Elementary/Secondary (0-12) 12TH	College (1-4or 5+)		OO NOT use retired.		ER S	STATE	OF M	ARYL!	7ND
Maryland	d ta b	To Be C	17. Father's Name (First, Middle, Last) ELLIOTT H. PARH.	AM				ne (First, Middle, M		ame)		
Mary	12 sh hand 7 is m traum		19a. Informant's Name/Relationship (Type MARKAYLA T. LEE	e, Print)				ral Route Number, EDGEV	-			
	Head Head		20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of atory or other place	1			- City or To		
Baltimore,	Pages tment of I tant: If Its jury or o		M Surial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State M7	CAF	MEL CEM	03/0			MORE,		
Ball	permit. Pag Department Important: I eny Injury o 2005.		21. Signature of Funeral Service Licensee	X. Xour				WELL FUEIGHTS A				
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۵.	ires that t signed by I be detac	þ	Part II. Other significant conditions cont	nbuting to death but not res	ulting in the ur	derlying cause give	en in Part I.	23e. Did tob	\/	ntribute to th		leath? Jnknown
Division of Vital Records,	he law require e has been si ige 2 should l	Completed	\					24a. Was ar autops perform	245	o. Were auto prior to cor death?	osy findings npletion of c	
a	ician: Th certificate rector, pag	O	25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·		26. Place of Dea	th (Check only on		1 🗆 Yes	2 No	
<u>></u>	Physician: The this certificate har al director, page	ToB	To res 2 x No		ER/Outpatien		4 🗆 Ruising n	ome 5 Reside			")	
ono	ding P	tion:	27. Manner of Seath 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	yat k? Yes 2 ∐No	28d. Describe ho	w injury occ	urrea		
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	To the Hospital or / within 24 hours efter To the Funeral Dire completely filled in b	Medical C	29a. Certifier 150 Certifying Physic (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and rate and place	manner as s e, and due to	ated. the cause(s	;)
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	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa		and I		-1/2 3/104	1		/	

			1 = For State Registrar		Si	tate o	of Maryla	nd / Depa <i>Cei</i>	artment <i>tificate</i>			and M	lental I		ene No. 0 (16	057	45
	Physici	an	Decedent's Name	(First, Middle	e, Last)						_		2. Date of		Dav	Year	3. Time o	/ Death
	/Medic		Mary				igton						Febru	ıary	23, 2	2006	7:45	Рм
1	Examir	er	4a. Facility Name (If			at and nu	mber)		4b. City, To			f Death			4c. County			
			5. Social Security No		d 6. Sex		7 Age /In urs	. last birthday)	Dur.	dall	If Under :	D4 Hrs	9 Data at	Diah	Bali	imor		
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	and		Usual Residence of 10a. State	10b. County			10c. C	ity, Town or Lo	cation						-	1	Od. Inside C	City Limits
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-	e deal	Physician/M	in the past 12 r		4		nant at time of		Other (spec					_	Мо	onth	Day	Year
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of Vital Records,	8 50	d by	Part II. Other significant	Cant condition	AIS COMINDO	iting to u	eath but not re	suiting in the ur	iderlying cau	se giver	ın Part I.			Ves	cco use cont		e cause of a ably 4 🗌	
000	faw require as been si 2 should i	ompleted											24a. V	Vas an	24b.	Were auto	osy findings	available
æ	The la	mo											P	utopsy erforme	d?	prior to cor death?	npletion of a	ause of
Ita		BeC	25. Was case referre	ed to medical							26. Place	of Death	1 Ye		No	1 🗆 Yes	2 LI NO	
<u>></u>	Ys is	2	examiner? 1 ☐ Yes 2 ☑	10	Hospi	tal: 1 🔲	Inpatient 2] ER/Outpatien	t 3 DOA	Other				-	e 6 □Oth	er (Specif)	1)	
0	De je	ë	27. Manner of Death 1 Natural	5 Pendin		Ba. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	280	Injury a	at	2	8d. Descri	be how	injury occur	red		
<u>s</u>	2 2 2 3	cati	2 Accident 3 Suicide	investig 6 🗆 Could r	not be				М		es 2 🗆 N	-						
Division	ial or Attendir s eftar death. al Director: Al ed in by the fu	Certification;	4 Homicide	determ		Be. Place buildi	of Injury - At hing, etc. (Speci	nome, farm, stra	eet, factory, o	office		2		n (Stree Town, S	et and Numb State)	er or Rura	l Route Nun	iber,
	To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by th	edical (29a. Certifier (Check only one)	1 Certifyin 2 Medical	EXAMINITES;	On the b	best of my kn asis of examin ner stated.	owledge, death ation and/or inv	occurred at restigation, in	the time my opir	, date and nion, deat	l place, a	and due to ed at the tir	the caus	se(s) and ma	inner as st and due to	ated. the cause(s	s)
	To th withir To th comp	Me	29b. Signature and t	itle of certifier					29c. L	icense	number			29d.	Date signe	d (Month,	Day, Year)	
	1			1			,			0	45	39	0	F	clase	an	124,	2006
6	1		30. Name and addre	ss of person	who comple	eted caus	se of death (Ite		Print) Po	ad	中2	805	Bo	ilti	non	- N	w2	1230
É	Sta	te	31. Date filed (Month		- 7	-	trar's Sign							A COLUMN				
	Registr	ar		FEB 2	7 200	16	Date on a	K	Track s									

ORIGINAL

			For State Registrar	State of Maryla	and / Depa	artmer rtificat	nt of He	ealth a Death	nd M		Reg. No.	006	S 0 ,	
	nysicia Medic		1. Decedent's Name <i>(First, Middl</i> e, Last) Walter Lewis Philli	lps, III						2. Date of De Month Februa	ath ry 20	, 2006	3. Time o	
	xamin		4a. Facility Name (If not institution, give st Mercy Hospital	reet and number)		,	Town, or	Location of e	Death		4c. (County of De	ath	
	neral ector		70 // 02	7. Age (In y. M 2 F 33	rs. last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir Month, Da July 3	th 19, Year) 197	2 Mai	irthplace (State Country) ryland	or Foreign
Maryland	in pagi	tor	Usual Residence of Decedent 10a. State 10b. County MD N/A		City, Town or Lo								10d. Inside 0	City Limits s 2 ☐ No
with the	the not	I Director	10e. Street and Number 218 S. Vincent Stre	eet		10f. Zi	Code				10g. Citiz	en of What (Country?	
5-UU30 72 hours after death with the Maryland	svent, the Medical Examinar must be notified at	by Funeral	11. Marital Status	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 Yes		spanic Orig n, Mexican, Specify:	in? (Spe Puerto I	cify Yes or No Rican, etc.)		4. Race - An Black, Wh Specify: W		
within 72 hours	e Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	kind of we DO NOT i	ise retired)	urina most	of workii	ng		d of Busines	ss/industry	
Maryland ZIZIS-UUSO td 2 should be filled within 72 hours aft lith and Mental Hygiene.	tic svent, th	To Be Co	o 17. Father's Name (First, Middle, Last) Walter Lewis Philli	ips, II	Never	WOL				(First, Middle				
E, IVICITY 1 and 2 show 1 and 2 show 1 and 27 lame	ther trauma		19a. Informant's Name/Relationship (Type Carolyn L. Seigle/N 20a. Method of Disposition	Mother	218 b. Place of Disp	S. Vi	incen	t Str	eet	/Route Numb Baltim Date	ore	MD 212		
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Mental Important if item 27 la marked.	any injury or or one one or		1 Burial 2/2/Cremation 3 Re 1 Donation 5 Other (Specify) 21. Sonature of Funefal Service License	emoval from State We	est Arun	matory or Idel (2. Name a .mbros	other place Crema nd Addres Se Fu	tory s of Facility neral	Hom	-2006 e, Inc	0dent	on, Ma	aryland	
Physical Processing Physical P	ician and dical niner transit principle of p	ical Examiner	23a. Pall 1. Enter the disease, of complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to fine edistications. If any, leading to fine edistications (Disease or injury that initiated events resulting in death) Last	3/)	sequence of): Tum (sequence of):	iter the mo	de of dying	, such as	cardiac c				Approxima Interval Be Onset and 2 mo	etween d Death onth
P.O. BOX 58 nat the death certifica	hed by the attending pny detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	□Ectopic (□ Other (s			7000		2	3d. Date of o	delivery Day	Year
uries that	<u> </u>	by	Part II. Other significant conditions con	stributing to death but not	resulting in the	underlying	cause give	on in Part I.			tobacco u Yes 2[to the cause of Probably 4	
The ta	page 2 should t	Completed								24a. Wa auto perf 1 🗌 Yes	s an opsy ormed? 2 L No	24b. Were prior to death		s available cause of
n Of	or: Atter this certificate ne funeral director, paç	To Be	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatie		28c. Injury Work	9r: 4 □ Nu	rsing Ho	n (Check only me 5 ☐ Res 28d. Describe	idence (y occurred		
DIVISION To the Hospitel or Attending within 24 hours after death.	To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Abuilding, etc. (Sp.	At home, farm, s ecify)	treet, facto	ry, office			28f. Location City or To	(Street an own, State	d Number or)	Rural Route Nu	mber,
e Hospi	e Funer letely fill	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, dea mination and/or i	ith occurre nvestigation	d at the timen, in my of	ne, date an pinion, dea	d place, th occurr	and due to the red at the time	e cause(s) , date and	and manner place, and o	as stated. due to the cause)(s)
To th	To the	Me	29b. Signature and title of certifier Public	1		-		497	F		Fel	5,21	S L Z O	06
	Ì		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type	p, Print) 人のよ(€ 5	stree	+ , ;	Baltie	uore	MD	2123	0
*	Sta Regist		31. Date filed (Month, Day, Year) FEB 2 7 200	32 Registrar's S										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 21 per DVR C852 02/27/06dhb
State of Maryland 1 bepartment of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2, 8:00p.m. **February** 2006 Jacob Theodore Pritzker /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Sandy Spring Friends Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. May 23,1908 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 € M 2 □ F **Tllinois** 354-09-4834 97 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show Examining the notified at 1 Yes 2 No Director Sandy Spring MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 20860 TISA 17401 Norwood Road Items 23e death 1 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If itam 27 is marked othar than "netural", or iter 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 ☐ Divorced Year or Dates: 142–46 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Statistician Pentagon 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lily Vey Cohn Louis Jacob Pritzker 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Susan Lovegarden/daughter 305 Saddlerock Circle Sedona, AZ 86336-5712 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) permit. Pages
Department of Important: If it
any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 Sonation 5 ☐ Other (Specify) 22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street 21. Signature of Funeral Service Licensee Ronald S. Wade, Director per DVR Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caus at the shock, or heart failure. List only one cause on each ine. such as cardiac or respiratory arrest eath. Do not enter the de of dying Immediate Cause (Final disease or condition resulting in death) em Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner the Hospital or Attanding Physicien: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day Month ō in the past 12 months? 1 ☐ Yes 2 ⊡ No 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, should be 3 ☐ Probably 4 ☐ Unknown 2**√**2 No 1 Tes Be Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed page 2 1 Yes 2 No funeral director, 26. Place of Death (Check only one) 25. Was case reterred to medical examiner? Other: 4 Mursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 2 No Medical Certification: To 1 Tyes this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of er of Death 27. Man 1 Natural Injury 5 Pending investigation 1 Tyes 2 🗌 No death. 2 Accident Diractor: Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier who completed cause of death (Item 2:a) (Type and address of p son MW 12 32. Registrar's Signature 31. Date filed (Month, Qay Year) State aser. 7 2006 Registrar

			1 - State of Maryla		artment of Health and Martificate of Death	Mental Hygier	ZIIII	05748
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Yeer	3. Time of Death
ı	Physici: /Medic		Ruthe K. Pendleton			-	15, 2006	7:55 PM M
	Examin		4e. Fecility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Deeth	
			Washington Adventist Hospita		Takoma Park		Montgome	
	Funeral		10 M 200 E	rs. last birthday) 33 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Yea	ar) Cou	plece (State or Foreign untry) unk
	Director		578-26-2067	,,,		Sept 5, 1	922	
	/land		10a. State 10b. County 10c.	City, Town or Lo				10d. Inside City Limits
	Many a-f sh	ţō	MD Montgomery	Takoma	Park			1 ☐ Yes 2√ No
	th the	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cor	untry?
	23a		7051 Carroll Avenue		20912		USA	
	er dez	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	s afte	by F	1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specify:		Specify: wh	ite
8	filed within 72 hours after death with the Maryland Hygiene. the than "natural", or tlams 23a or 28a-f show int, the Medical Exacilmet fount be notified at	edt	15. Decedent's Education	16a. Dece	dent's Usual Occupation	unk 16b	Kind of Business/l	
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21	giene grene	Completed	unk unk					
9	0 = 0 5	Be (17. Father's Name (First, Middle, Last)		unk 18. Mother's Nam	e (First, Middle, Maid	len Sumame)	unk
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Itamis 23a or 28a-1 show any jointy or other traumatic event, the Medical Extr. ither rotal be notified at once.	ပ္					- Out 7	". O. J.)
Jar	2 sh and le m		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Rui			
e,	1 and Health em 27 ther t		Washington Adventist Hospital 20a. Method of Disposition 20	b. Place of Dispo	Carroll Avenue Ta		MD 209 Location - City or	
وّ	nt of h		1 Burial 2 Cremation 3 Removal from State	cemetery, cre	matory or other place)		,	
altimore,	it. Partmer		'4 □ Donation 5 ☒ Other (Specify) in state	2:	2. Name and Address of Facility			
Ba	Depa Impo any i		21. Signature of Funerat Service Licensee Ronald S. Ward Direct		2. Name and Address of Facility tate Anatomy Board altimore, MD 2120		altimore	Street
			23a Part. Enter the disease, or complications that caused the co					Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	. 6	wal a mus so the			Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a con	sequence of):	Cardiouscula	-		
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	and -trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a con	sequence of):				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Icai E	330 to (0, 20 2 55.)					
587	icate phys s the		d					
Вох 6	es that the death certific igned by the attending p be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pre		Te		23d. Date of deli	ivery
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O.	t the by the	hys	9 ☐ Unknown					
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ord	w requir been si should	ted	Dementia			1 🗆 Yes	2LIN0 3LIP	obably 4 Munknown
Records,	has be ge 2 sh	Completed				24a. Was an autopsy	prior to d	topsy findings available completion of cause of
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of Vital	ding Physician: The I h. After this certificate ha funeral director, page	Be	25. Was case referred to medical examiner? Hospital:		Cthor	th (Check only one)		
of	Phys this ral dir	. To	1 Yes 2 No 1105phan 1 Inpatient 27. Manner of Death 28a, Date of Injury	2 ER/Outpatie	nt 3 DOA 4 Nursing H	ome 5 Residence 28d. Describe how i		cify)
no	ding h. After fune	ţ	1 Natural 5 Pending (Month, Day Yea	r) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division	Attending it death. ector: After by the fune	fica	3 Suicide 6 Could not be 28e. Place of Injury -	At home, farm, st	reet, factory, office	28f. Location (Stree City or Town, S		ıral Route Number,
ă	al or A s after il Direction by	Certification:	4 Homicide determined building, etc. (Sp.	ecity)		City of Town, S	(210)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my cone) 1 Medical Examiner: On the basis of examone and manner stated.	knowledge, dea mination and/or is	th occurred at the time, date and place evestigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Mont	h, Dey, Year)
	- > - 0		& Elwan blow		42936	FR	buory 16	2,2804
			30. Name and address of person who completed cause of death	(Item 23a) (Type	, Print)			
			DR. ELWIN G. BUSIOS					
		ate	31. Date filed (Month, Day, Year) FEB 2 7 2006 32 Registrar's S	Signature	and of			
	Regist	ıaı	1 20 6 1 2000	and the same				

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ORIGINAL

			1 - For State Registrar		f Maryland		artmen tificate					Reg. No.	006	05749
	Physici	an'	Decedent's Name (First, Middle	, Last)					_		2. Date of De. Month 02	_	2 O ^{Year}	3. Time of Death
	∍/Medic		Brenda		Leah			Ree			02	18 ^{pay}	2006	
	Examir	ier	4a. Facility Name (If not institution		nber)				Location of			4c. C	County of Dear	th
*	• • •		Sinai Hospita 5. Social Security Number	3. ⊥ 6. Sex	7. Age (In yrs. In	ast birthday)	If Under		If Under		8. Date of Birt	h	9 Bid	hplace (State or Foreign
	Funeral Director		219-26-7520	1□M 210F	67	Yrs.	Months	Days	Hours	Min.	08 1	4 Year) 3	8	hplace (State or Foreign ountry) MD
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	show	_	10a. State 10b. County			, Town or Lo								10d. Inside City Limits
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21215-0036	d within 72 hours after dea piene. r then "neturel", or Items the Medical Everimet on	Completed	15. Decedent (Specify only highes			16a. Deced	ient's Usua kind of wor	al Occupa	ition	t of worki	10	16b. Kin	d of Business	Industry
2	within ene.	npie	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. I	DO NOT us	se retired,	,					
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anc	be d	Be						,			(First, Middle, olmes	maiden S	sumame)	
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JO.	Pages nent of I int: If it		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	rpent				2/2:	3/06	Sev	verna	Park, Md
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Service		, 00	Ma Ma	. Name an	d Addres F/H	s of Facilit	t t				21215
			23a. Part 1. Enter the disease, or	complications that o	aused the death						Balti r respiratory ar		e, na	Approximate
	Physician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	Ather	osclero	tic	He	art	Dis	case			Interval Between Onset and Death
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Д.	res that igned b be deta	by Pl	Part II. Other significant condition	ns contributing to de	eath but not resu	lting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	obacco us	e contribute to	the cause of death?
rds	w require been sig should b										101	fes 2□	No 3□Pr	obably 4 Dunknown
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n of		lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pendin	9	of Injury th, Day Year)	28b. Time of Injury		8c. Injury Work	at	2	8d. Describe			
Sio	i at ii	icat	2 Accident investig	not be	-4 Inium. As ha		M		/es 2 □ I		19f Lanation (74	Alambaras Or	ural Davida Musika
Division	el or Attens s after deat of Director: od in by the	Certification:	4 ☐ Homicide determ		of Injury - At hor ng, etc. (Specify		eet, factory	, office		•	City or Tov	vn, State)	Number or At	ural Route Number,
	To the Hospitel or Atte within 24 hours after der To the Funerel Directo completely filled in by th	edical (29a. Certifier 1 Certifyin (Check only one)	g Physician: To the Examiner: On the band man	best of my know asis of examinati ner stated.	wledge, death ion and/or in	occurred a	at the tim	e, date an pinion, dea	d place, a	and due to the	cause(s) a date and p	and manner as place, and due	s stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certified	,	111	7	290	. License	number			29d. Date	signed (Mont	h, Day, Year)
1	7		I Kraller	LA.	klin			D4	347	6		Feb.	rvary 19	3,2006
17	V	1	30. Name and address of pers	who completed caus	e of death (Item	23а) (Туре,	Print)						0	2, 200 C
1			Brodenik J	Frank	lin, M	-	401	W.	Bel	vede	se AY	E	Baltimo	E, MO 21215
\$.	Sta Registr	-	FEB 2 7 2006	32. R	egistrar's Signat	DEANS!								

-6.17	Baltimor
RICHARDSON	
ALVINA RICHA	on of Vital Records, P.O. Box 68760,

						•	Cer	tificate of	Death	•	Reg. No.	ib U	5/50
	Dhyoia		1. Decedent's Name	(First, Middle, La	ist)					2. Date of D Month			3. Time of Death
4	Physic /Medi		Alvina F	Richards	on					FEBR		Yeer	2:20 PM
	Exami		4a. Facility Name (If		e street end nun	nber)			4b. City, Town, or	Location of Dea	th 4c. County	of Death	
			MANOK		FNOR			MAIN AND AND AND AND AND AND AND AND AND AN	PRINCE			OMER	
	Funeral		5. Social Security Nu		Sex 1□M 2√⊋F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Yea Months Days		(Month, D	irth Pay, Year)	 Birthplace Country; 	e (State or Foreign
	Director	ļ	213-12-60 Usual Residence of D	124	-X	86	115.			May 29	9, 1919	Mary:	land
	land			10b. County		10c. City	, Town or Loc	cation				10d.	Inside City Limits
	Marylan -f show led et	ō	MD	Somerse	et		Prince	ss Anne					1 ☐ Yes 2√∏ No
	r 28a	ec	10e. Street and Num	ber				10f. Zip Code			10g. Citizen of V	What Country	?
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "netural; or items 23a or 28a-f show event, the Mcdical Examiner must be inclified at	Funeral Director	11974 Ed	gehill 7	Terrace				21	853	US	A	
	deat	ner	11. Marital Status		12. Was Dece Armed For	dent Ever in U,	S. 13. V	Vas Decedent of	Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or N		ce - American	
Ö	after or ite		1 Never Marrie		1 ☐ Yes If Yes, Give	21⁄2 No		☐ Yes 2 ☑ No		O Hican, etc.)			
000	Iral',	d by	3 🖾 Widowed 4	Divorced	Year or Da	ites:		X	opouny.		Specify	whit	е
21215-0020	72 h	Completed	(Specif	 Decedent's Expression only highest great 	ducation ede completed)		(Give I	ent's Usual Occu	e during most of wo	rking	16b. Kind of B	usiness/Indus	try
12	vithir ne. han	臣	Elementary/Second	dary (0-12)	College (1	-4or 5+)		OO NOT use retir	ed)				
	filed with Hygiene. ther than		17. Father's Name (F	iret Middle Last	0		ho	memaker	19 Mathada No.	ma /First Middle	own h		1-
au	e da da y	Be	_		/				IB. WOULD STVA	ne (First, Iviidali	e, warden suman	10)	unk
$\tilde{\Sigma}$	should ind Men marke umatic	ဥ		Cook Sr	To a Delant		40h 44-111-					0 7. 0.	
Maryland	0 6 6 6	9	19a. Informant's Nan					,	et and Number or Ru			State, Zip Co	ide)
	of Health Item 27	1	Linda Ba		ghter	20b. PI		Cherry sition (Name of	Walk Hebr	on, MD Date	21830 20c. Location -	City or Town	State
٥	Pages nent of I int: If Ite		1 🗆 Burial 2 🗔	Cremation 3		0.0		natory or other pla	ace)	Dute	Zoc. Location	Oily of Town,	, State
Baltimore,		- 5	4 ⊠Donation 5					Manage 1 A 116	and of Facility				
Ba	permit. Depertuimporta eny inju		21. Signature of Eug Rd	nald S.	Wade	irector	22	state An	ess of Facility atomy Boa	rd 655	W. Balti	more S	treet
			June	my	1/100			Baltimor		201			
			23a. Part1. Enter the shock, or heart	disease, or com failure. List only	plications that ca one cause on ea	used the death ach line.	. Do not ente	er the mode of dy	ring, such as cardiad	or respiratory	arrest,	Ar	pproximate terval Between
7	Physician /Medical		Immediate Course /F		00	0/	\sim	00		-	· · ·	01	nset and Death
	Examiner		Immediate Cause (F disease or condition resulting in death)	ınaı	a chd	>tag	e a	Kylie	imers	Vam	entra	5	, you
		<u>-</u>	3 ,			Due to or	as a consequ	uence on:				1	,
	ted nsit	nin.		•	b			,				<u> </u>	
	certificate be executed uding physician and use es the buriel-transit	Examiner	Sequentially list condif any, leading to immoduse. Enter Underly Cause (Disease or in	ditions, nediate		Due to (or	as a consequ	uence ot):				1	
260	sicial sicial		Cause (Disease or in that initiated events	njury	C	Due to /or							
68760,	ificet g phy es th	/Medical	resulting in death) La	ıst		10) 01 800	as a consequ	ierice oij.					
Вох	- 63				d				•				
	Physician: The law requires thet the death this certificate has been signed by the atterrial director, page 2 should be deteched for	Physicial	Part II Other signific	ant conditions of	ontributing to dea	ath but not resu	Iting in the un	derlying cause g	iven in Part I.	23b. Dic	l tobacco use co	ntribute to th	e cause of death?
P.0	by the	پار	(6)	0:0	271	con t	-	4		1	Yes 2 No	3 Probab	oly 4 □ Unknown
	ss the gned be de	by	C SSE	wia	CAL	peri	ense	~					
ord	v require been si	De le	Fail.	120 1	- 11	1				24a. Wa	s an autopsy formed?	24b. Were availa	autopsy findings
ည	aw re as be 2 sh	ple	V	1	0 /10	viii						compl of dea	letion of cause ath?
œ	The law sate has page 2	Completed								1 🗆	Yes 2⊠No	1 🗆 Y	′es 2,⊠SNo
ita	ician: The	Be C	25. Was case referre	d to medical					26. Place of Dea	ath (Check only	one)		
of Vital Records,	ysicis is cert direct	To	examiner? 1 □ Yes 2 ⊠ N	o	Hospital: 1 ☐ Ir	patient 2 E	ER/Outpatient	3□ DOA O	ther: 4 Nursing H	lome 5 🗆 Res	idence 6 □Oth	er (Specify)	
0	ding Phy h. After thi funeral	ä	27. Manner of Death 1 Natural	5 Pending	28a. Date o	f Injury n, Day Year)	28b. Time of Injury	28c. Inju Wo	ury at	28d. Describe	how injury occur	red	
<u>.</u>	Attending or death.	atic	2 Accident	investigation	n	, , , ,	,,		Yes 2□No				
Division	or Attend efter death Director: /	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	286. Place	of Injury - At hor g, etc. (Specify,		et, factory, office)	28f. Location City or To	(Street and Numb own, State)	per or Rural Re	oute Number,
	irs efter or rel Dir	Ce											
	e Hospitei 124 hours Funerei	edical	(Check only 2		niner: On the ba	sis of examinati			ime, date end place opinion, death occu				
	To the Hospitel or within 24 hours effet To the Funerel Dir completely filled in	Med	one) 29b. Signature and til	tle of certifier	and mann	er stated.		29c Licen	ise number		29d. Date signe	d (Month Da	v. Year)
	5. <u>¥</u> ₹ 8				1 /B	100.	10			_			
			Mag	gres n	r, we	class,	"AL	1 -	29505		02-1	6 - Z	006
			26. Name and address						A	11100		D 42	(GA)
	C.		GREGORI 31. Date filed (Month)		32. Re	gistrar's Signat	ure A	MADURA	VKUS	ALITA	AM / 141	V 21	001
	Sta Registr		E		006	gistrar's Signati	A AM						
				have that I go be	- Burg	all a	- 1						

			State of Maryland / Department of Health and Me Certificate of Death	ental Hygie	Z U U O	05751
	Physic /Medi Examir	al	1. Decedent's Name (First, Middle, Last) MARGARET A. RHUADS	2. Date of Death Month	Day Year 6	3. Time of Death
	Funeral Director	lei	Franklin Square Hospital Rospitale	8. Date of Birth (Month, Day, Ye	Box / +1 () ar) 9 Birthp Count	DOC lace (State or Foreign try) USY IVANIA
	e-f ehow	ctor	10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
5-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 le marked other than "netural", or items 23a or 28e-f show other treumatic event, the Medical Examiner must be notified at	ed by Funeral Director	3 ☐ Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 ☑ No Specify:	irty Yes or No- lican, etc.)	Citizen of What Coun US A 14. Race - Americ Black, White, Specify: WH	an Indian, atc.
21215-	filed within 72 Hygiene. Ither than "net ont, the Medici	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-for 5+)	g 16b	. Kind of Business/Ind	
Maryland	should be file of Mental Hy marked oth matic event	To Be	17. Father's Name (First, Middle, Last)	RET	ten Sumame) NANCARIZ	OW)
Baltimore, Ma	0 0 = =		Comparison Com	PT A.2 20c.	SACTIME! Location - City or To	VE MD 21230 wn, State
Balt	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licensee Ronald S. Wade Director State Anatomy Board Baltimore, MD 21201		altimore S	treet
8760,	zate be executed make burial-transit the burial-transit	Ilcal Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Car Disess	Approximate Interval Batween Onset and Death 2. Conference of the
P.O. Box 6	The law requires that the death certificate be executed te has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delive Month	'Y Day Year
Records, P	w requires that been signed b should be deta	by	Part in Other significant conditions continuously to death but not resulting in the underlying cause given in Part i.	1.7		e cause of death? ably 4 □Unknown ssy findings available
tal Re		e Completed	Dr. Man and advantage of the state of the st	autopsy performed 1 ☐ Yes 2 🔼	prior to con death?	npletion of cause of 2 No
sion of Vital	Phy rthis ral d	ToB	examiner? 11 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther. 4 Nursing Home		6 ☐Other (Specify)
Division	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
	To the Hospital within 24 hours To the Funerel completely filled	fedical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, an and manner stated. Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, an and manner stated.	at the time, date a	and place, and due to	the cause(s)
	To with To	Σ	29b. Signature and title of certifier 29c. License number 29c. License number 2786	29d. I	13/06	Day, Year)
	Sta	té		IMOR	EMD.	21237
	Registr		FEB 2 7 2008 Flexing & Aprile			

			For State Registrar	State of M		epartm Certific			and Mental Hy	/giene	006	05752
	2 C .	20	Decedent's Name (First, Middle, L.	ast)					2. Date of D	eath		3. Time of Death
2	Physici		HENRY JEFFER	SON SAMPS	SON				Month Februa	rv 13	2006	6:17 a M
	/Medic Examin		4a. Facility Name (If not institution, ga			4b. C	City, Town, or	Location of			County of Death	1 0121 0
	LAU		311 W MOSHER ST	REET			BALTI	MORE			N/A	
V.	Funeral		Social Security Number 6.		ge (In yrs. last birt		der 1 Year	If Under		irth	9. Birth	plece (State or Foreign
	Director		249-70-6550	1∰M 2□F	63	rs. Mont	hs Days	Hours	June 2	9 194	2 SOUT	H CAROLINA
	P		Usual Residence of Decedent									
	aryta.	3.m	10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	89-f	cto	MARYLAND N/A			BALT	TIMORE					1 ∑ Yes 2 □ No
	ith th	Director	10e. Streel and Number			1 Of.	Zip Code			10g. Citiz	en of What Cou	ntry?
	ath w		309 W MOSHER S	7				1217			.S.A.	
	eb re	Funeral	11. Marital Status	12. Was Deceden Amed Forces	?	13. Was De If Yes,	specify Cuba	spanic Ori n, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	0- 1	 Race - Americano Black, White, 	
36	s afte	by Fi	1 ☐ Never Married 2 Narried 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	00100	1 ☐ Ye	s 2🛛 No	Specify:			Specify: BLA	r.K
8	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23a or 28e-f ehow La Mudical Exercia or Liusi De Lodiffed al		15. Decedent's I	Year or Dates		Danadaskal	laval Carvas					
5	n 72	Completed	(Specify only highest g		10a.	Decedent's t (Give kind or life DO NO	work done a Tuse retired	furina mosi	of working	TOD. KIN	d of Business/In	dustry
12	within Bne.	mc	Elementary/Secondary (0-12)	College (1-4or	, i	ECHAN]		,		т.	ONGSHORI	₽M ∧ N
9	other vent,		17. Falher's Name (First, Middle, Las	st)	1 19	ILCIIAIN.		18. Mothe	n's Name (First, Middle	· · · · · · · · · · · · · · · · · · ·		DUMIN
an	d be ental	o Be	HILLIE H SAMPS	OM				DO	CALLE MEAN	ED		
Maryland 21215-0036	2 should be and Mental ie marked isumatic ev	ဥ	19a. Informant's Name/Relationship		19b.	Mailing Add	ress (Street a		SALIE WEAV or or Rural Route Num.		Town, State, Zin	Code)
M	s 1 and 2 should be filed within 72 hours after death with the Manylan If Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23a or 28e-f show other traumatic event, it.e. Wedical Exerta ar intra		Nevater Sampson/						et, Baltim			
ම	Health Health tem 27 I	1 8	20a. Method of Disposition	MITE	20b. Place of	Disposition (Name of		Date Date		ation - City or To	
2	Pages nent of I ont: If It		1 🔀 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		GARRIS	y, crematory`	•	1	02-22-06	OMENI	CC MITT	CIVE TYPERM
Baltimore,	artme present injur		21. Signature of Funeral Service Lice		GARRIS							S, MARYLAND
Ba	permit. Pages Department of Importent: If II any injury or o		Barbarac	Beron			W NOR!		OMMUNITY ENUE	FUNE	RAL HOMI	E P.A.
1			23a. Part1. Enter the disease, or co- shock, or heart failure. List onl	mplications that cause y one cause on each	ed the death. Do n line.	ot enter the	node of dying	g, such as	cardiac or respiratory	arrest,		Approximate Interval Between
18	Physician		Immediate Cause (Final disease or condition	- Lu	na	Car	ces	رم			6	Onset and Death MONTHS
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence o					-		
	LAdiffiller		Sequentially list conditions,	b								
	pg tis	lue	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence o	of):						
	and -tran	Examiner	that initiated events resulting in death) Last	C. Due to (or a	s a consequence of	of\.						
8760,	cate be executed physicien and s the burial-transit	E		200 10 (0. 2	o a consequence	,,,,						
87	cate physi the	dical	•	d							-	
9 x	n certifica ending pl use as t	Physician/Me	IF FEMALE:	23c. If yes, outcom	e of pregnancy						04 0-14 4-1-	
Вох	death certif e attending ed for use as	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 Fetal death	3 ☐Ectop 5 ☐ Other	c pregnancy			2.	3d. Date of deliv Month	ery Day Year
o.	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	at tillie or death	3 🗀 O((1)6)	(spacity)					
Φ.	requires that the di een signed by the hould be detached		Part II. Other significant conditions	contributing to death	but not resulting in	the underlyi	ng cause give	en in Part I.	23e. Did	tobacco us	e contribute to t	he cause of death?
ds,	signed d be del	d by	Done						1,25	Yes 2]No 3 ☐ Prol	bably 4 Dunknown
ö	~ 0 0	Completed							24a. Wa	5.20	24b Word aut	andy findings available
ž	has has	E D							aut	opsy formed?	prior to co	opsy findings available empletion of cause of
 	ician: Th certificete ector, pag			T					1 ☐ Yes	2 No	1 🗆 Yes	2 No
Vital Record		Be.	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	aCI50/0		Othe	ar	of Death (Check only		The same	Daughters
ō		. To	27. Magner of Death	1 ☐ Inpat 28a. Date of In (Month, D			DOA	4 LI NU	rsing Home 5 Res			Momé Homé
on	ding h. h. After funer	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigate		ay Year) Ir	njury M	28c. Injury Work	(? Yes 2 🔲		. ,		
Division	or Attending after death. Director; After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Ir	njury - At home, far	rm, street, fac	ctory, office				Number or Run	al Route Number,
ă	P in it	Certification:	4 Homicide	building, e	etc. (Specify)				City or To	own, State)		
	Hospitei	-	29a. Certifier 12 Certifying F	Physician: To the bes	t of my knowledge	, death occur	red at the tim	ne, date an	d place, and due to the	e cause(s)	and manner as s	stated.
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medical Example)	aminer: On the basis and manners	of examination and	d/or investiga	lion, in my or	oinion, dea	th occurred at the time	, date and	place, and due t	o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie	P	1		29c. License	number		29d. Date	signed (Month,	Day, Year)
	1		> Uller) test	X		200	38.	578	02	123/0	06
10	101		30. Name and address of person who	o completed cause of	death (Item 23a) (Type, Print)					, , -	
W			Dr. Robert Fent					more,	Maryland	21201		
	Sta		31. Date filed (Month, Day, Year) FEB 2 7 20	Regis	trar's Signature	Anna N	,					
\$	Registr	ar	reba (Zl	IUO Andrews	and the of							

Glenn Simms 06-1310 AKG

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ise Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
State of Maryland / Department of Health and Mental Hygiene	n i
Certificate of Death	U,

,		•	State Registrar	•	Certificate of Dea	ath	Reg. N	4 U U O	U 0 / 0 0
	Physici		Decedent's Name (First, Middle, Last)				Date of Death Month	ay Year	3. Time of Death
	/Medic		GLENN		SIMMS	5	February	r 21, 2006	7:00 P M
	Examin	er	4a. Facility Name (If not institution, give str		4b. City, Town, or Local	tion of Death	4	c. County of Death	
			1905 West Baltimore		Baltimor		D. 1 (D) . (b)	n/a	
	Funeral Director		5. Social Security Number 6. Sex 120-54-4079 129. N	7. Age (In yrs. last birt	Months Days Hou	urs Min.	Date of Birth (Month, Day, Yea ARCH 21, 1	Coul	place (State or Foreign ntry) RYLAND
	land ow	1	10a. State 10b. County	10c. City, Towr	or Location			1	10d. Inside City Limits
	deeth with the Maryland me 23a or 28a-f ehow rouat be notified at	ğ	MARVIAID N/	a l	BAI	TIMOR	E CI	T1/	1. Yes 2 No
	r 28a	Director	10e. Street and Number		10f. Zip Code	TIMOR 1223	10g. C	Citizen of What Cou	ntry?
	th with		1905 W. B	ALTIHORE S	T. 2	1223		451	7
		Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Specify	Yes or No-	14. Race - Americ Black, White,	
21215-0036	within 72 hours after ene. then "natural", or ite he Medical Exposite	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:	-	ecity:	,,	Specify: BL	
5-0	72 ho	Completed	15. Decedent's Educa (Specify only highest grade of	ion 16a.	Decedent's Usual Occupation	most of working	16b.	Kind of Business/In	dustry
21	ithin ie.	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during life. DO NOT use retired)	most of working			
	71	S	4 HGRADE		SUPERVIS			DAREL	HOUSE
Maryland	a la b	Be	17. Father's Name (First, Middle, Last)		18. A	Mother's Name (Fi	rst, Middle, Maide		
3	s 1 end 2 should be f Haalth and Mental item 27 is marked c other traumatic eve	၉	CHARLES	0 <u>//</u>	E	TELE	N	SIM	
Mai	12 st hand 7 ien traun	1	19a. Informant's Name/Relationship (Type		Mailing Address (Street and No				
	s 1 end 2 f Haalth item 27 i		FRANK THOMAS 20a. Method of Disposition	(COUSIN) /	Disposition (Name of	Date		Location - City or To	40.21223
ğ	ages nt of nt of nt of		1 ☐ Buriai 2 ☐ Cremation 3 ☐ Rer	noval from State	y, crematory`or other place)	114 3		•	
Baltimore,	permit. Pages Department of Important: if i any injury or o	1	4 □ Donation 5 □ Other (Specify) 21. Sign turn of Fundral Service Lorenge	METR	O CREMATORY 22. Name and Address of F	Facility A	-06 10	ALTIMOR	EMD.
Ba	permit. Departn imports any inju		$\mathbb{N}_{\mathcal{N}}$	(ton)	JO, SEPH	HIOK	OWN I	BALTO, 1	RAL HOME
			23a. Part1. Enter the disease, or complica	tions that caused the death. Do r	ot enter the mode of dying, suc	ch as cardiac or re		SALIO, 1	Approximate
	Disc. 1.1.		shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	70				Interval Between Onset and Death
	Physician /Medical	- 1	disease or condition resulting in death)	Due to (or as a consequence of	u comon	0-			
	Examiner			Due to (or as a consequence t	л,.				
		Jer	Sequentially list conditions, if any leading to immediate	Due to for as a consa uence of	of L:				
CX	ecuted and I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
0,	The law requires that the death certificate be executed to has been signed by the attending physicien and baga 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a consequence of	of):				
68760,	ate be physici the bu	Medical	d.						
89	ertificati ling phy e as the	Med	IF FEMALE:						
Вох	eath ce attendi for use	-	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy			23d. Date of delive Month	ery Day Year
	of the dea by the at tached for	sici	1 Yes 2 No	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			Month	Day Tea:
P.0	thet the	Completed by Physician	Part II. Other significent conditions contr	huting to death but not regulting in	the underlying eauce given in E	Part I	23a Did tobacci	o use contribute to t	he cause of death?
S	signe d be o	þ	() and M	cal dir ha	the underlying cause given in t	art i.		2 □No 3 □ Prot	
Ö	w requir been s should	etec		-6701(3)					
3ec	e law has l	d L					24a. Was an autopsy performed?	24b. Were auto prior to co death?	opsy findings available emptetion of cause of
a							1 Yes 2 1		2 □ No
Ζ	sicien certifi rector	Be	25. Was case referred to medical examiner?	pital: 4 5 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	1	Place of Death (C			
o	Phys rthis raldi	6	1 X es 2 No No 27. Manner of Death	1 Inpatient 2 EH/Ou	tpatient 3L DOA 4		5 Residence . Describe how in		Mat scene
on	nding Physicien: ath. r: After this certific e funeral director.	후	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. T	ime of 28c. Injury at Work? M 1 Yes				
Division of Vital Records,	Attendi r death. ector; A by the fu	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, fa	rm, street, factory, office	28f.		and Number or Rura	al Route Number,
Ö	al or s afta ii Dire	Certification:	4 Homicide determined	building, etc. (Specify)			City or Town, Sta	1(0)	
	To the Hoepital or Attenwithin 24 hours aftar deall To the Funeral Director: completely filled in by the	Medical ((Check only 2 Medical Exemine	ian: To the best of my knowledge r: On the basis of examination an	, death occurred at the time, da	ite and place, and i, death occurred a	due to the cause at the time, date a	(s) and manner as s and place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Med	29b. Signature and little of certifier	and manner stated.	29c. License num			Date signed (Month,	
	5 7 K 7		1 Rail	Lo MAN		-			
	1		20. New Ord address of a second	ploted source of death (the source)	O.C.M.E.		Feb	ruary 22,	2006
	N/		30. Name and address of person who com		Type, Print) 111 Penn Stree	et Ralt-	imore M	arvland	21 201

State Registrar 31. Date filed (Month, Day, Year)
FEB 2 7 2006

32 Registrar's Signature

			1 - For State Registrar		larylan	d / Depa <i>Cei</i>	artment of I	lealth a	and Me		iene eg. No.	06 (1575	14
	Physici	an	1. Decedent's Name (First, Middle, Last Francis X. Sym						2	2. Date of Dea Month	Day	Year	3. Time of	Death
	/Media	al	Francis X. Sym 4a. Facility Name (If not institution, give		.1		4h Cib. Town	1		ebruar		2006	,,,,,,	PM
	Examir	er	Oak Crest Care C)		46. City, Town, o		of Death			unty of Death		
	Funeral		Social Security Number 6. Se.		ge (In yrs. I	last birthday)	If Under 1 Year	If Under		B. Date of Birth		timore 9. Birth	place (State o	or Foreign
	Director		181-18-5991	(M 2□F	86	Yrs.	Months Days	Hours	Min.	ct. 6,	1919	Cou	sylvan	-
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside Ci	
	f sho	lor	Maryland Baltimor	0			Parkville	2					1 Tyes	
	r 28a	Director	10e. Street and Number	C	1		10f. Zip Code			1	0g. Citizer	of What Cou		^
	th with	alD	8810 Walther Bl	vd.			2123	34				u.s.A.		
	r dea	Iner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.	S. 13.	Was Decedent of H	lispanic Ori	gin? (Speci	ify Yes or No-		Race - Ameri Black, White,		
36	s afte	by Funeral	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give	No.		1□Yes 2□No			, , , , ,	Sp	ecity: Whi		
9	iiled within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23e or 28e-f show ant, the Medical Esanikar must be Lotified at	edk	15. Decedent's Edu	Year or Dates:	- 1	16a, Dece	tent's Usual Occur	pation				of Business/Ir		
215	hin 72 an "na Medii	Completed	(Specify only highest grad		-5+)	(Give life. l	kind of work done OO NOT use retire	during mosi d)	t of working	7	TOD. IKING	01 003111033711	ladstry	
2	ad will giene er tha	Com	Elementary/Secondary (0-12) 12th Grade	College (1-40)	3+)	Insp	pector			(Gas &	Elect	ric Co	•
D D	tal Hydral Hydral even	Be	17. Father's Name (First, Middle, Last)							First, Middle, i		mame)		
Maryland 21215-0036	hould d Mer narke	ဥ	Joseph Symon	man (Print)		105 11 77				I. Ril				
M	id 2 si Ith an 27 is r traur		19a. Informant's Name/Relationship (Ty Bernadine Symon	wife)			ng Address (Street Walther					own, State, Zij 21234	o Code)	
ē,	f Healifem		20a. Method of Disposition		20b. Pl		sition (Name of natory or other pla		Da			ion - City or T	own, State	
Ë	Page net o nt: If		1 ☐ Burial 2 ☐ Cremation 3 🔀 • 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			Cemeter		/24/0	6 -	Johns	town,	PÅ	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Esantinet must be notified at anose.		21. Signature of Lineral Service Cigens	88		22	. Name and Addre	ess of Facilit	Schi	munob	Funon	al Ham	e s	
_	90E # 9		23a. Part1. Enter the disease, or compl			97	05 Betal	ル Rd.	, But	timore,	MD	21236		
8760,	Physician I/Medical Examiner but sign and physician and physician and sign	sai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury	ne cause on each	s a conseque	uence of):	01500						Interval Bet Onset and I	
O. Box 6	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Fetal	death 3	Ectopic pregnancy Other (specify)	у			230	. Date of deliv Month	,	/ear
rds, P.	quires that n signed I uld be det	by	Part II. Other significant conditions con	ntributing to death	but not resu	ulting in the ur	nderlying cause giv	ven in Part I.				contribute to t		
Records,	The law requir ate has been s page 2 should	Completed								24a. Was a autops perform	y	4b. Were auto prior to co death? 1 \(\sum \text{Yes}	mpletion of c	available ause of
Vital	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?					26. Place	of Death (Check only on				
<u></u>	hys this at di	2	1 ☐ Yes 2 ☐ No	fospital: 1 ☐ Inpat		ER/Outpatien	- Annual Property	4 (3410		5 ☐ Reside			fy)	
Division of	ding After fune	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury	Wor	ryat rk? ∣Yes 2 🗆 I	No	d. Describe ho				
DIX	Ital or Attandurs after deathrai Director:	Certifi	4 Homicide determined	28e. Place of Ir building, e	njury - At ho etc. (Specify	me, farm, str	eet, factory, office		28	f. Location (St City or Town	reet and N n, State)	umber or Rur	al Route Num	ber,
	To the Hospital or A within 24 hours after To the Funeral Director Completely filled in by	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	ner: On the basis and manner s	of examinat	wiedge, death ion and/or inv	occurred at the tile restigation, in my o	me, date an opinion, dea	d place, an th occurred	d due to the call at the time, d	ause(s) an ate and pla	d manner as s ace, and due t	tated. o the cause(s)
	To To Com	2	29b. Signature and title of certifier				29c. Licens	se number		2	9d. Date s	igned (Month,	Day, Year)	
	11		- an more					564	6		rebr	vary	20 2	006
10	0		30. Name and address of person who co	mpleted cause of	death (Item	23a) (Type,	Print)) 0	o sic	71:	LN	212	3 1/1	
	Sta	te	31. Date filed (Month, Day, Year)	32 Regist	trar's Signat	ture /	oute inco	Z Y	Cit (m)	ا در ره (7()	C (C		
	Registr	-	FEB 2 7 200	6	and the	1 60	ack)							

TRANCES Symon 2-18-06 7

			For State Registrar	State of Marylan	d / Departm			Mental H	ygiene Regi.No	06	05755
	Physici /Medic	an	Decedent's Name (First, Middle, Last)	SCHE	RR			2. Date of D Month FEB		Year	3. Time of Death
₩ ₁	Examin	er	4a. Facility Name (If not institution, give s Genesis Brightwoo 5. Social Security Number 6. Sex	treet and number)	4b. C	Luthe	r Location of Death erville			Baltime 9. Birth	
설	Funeral Director		212-36-5146 Usuel Residence of Decedent 10a. State 10b. County	M 2	Yrs. Mont	ths Days	Hours Min.	Jan 6,	1921		ginia 10d. Inside City Limits
	Remaryia 28a-f shov olified at	Director	MD Baltimo		Luthervil	.1e . Zip Code			10a. Citiz	en of What Co	1 ☐ Yes 2 ☐ No
	23a or 3	al Dir	515 Brightfield	Road #319			21093			USA	
000	be fled within 72 hours after death with the maryland tal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, it a Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1		ecedent of H specify Cubi es 2 🙀 No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or to Rican, etc.)		4. Race - Ame Black, White Specify: W	
0-617	thin /2 ho e. an "natur Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's (Give kind o life. DO NO	Usual Occup f work done IT use retire	during most of wo	rking	16b. Kir	d of Business/	Industry
N	be tiled htal Hygi od other event, I	Be	12 17. Father's Name (First, Middle, Last) Hyman Cohen	0	mea	at cut	18. Mother's Na	me (First, Mida		grocer Sumame)	У
lary	s 1 and 2 should be 1 Health and Mentall Item 27 Is merked o other traumatic eve	T _O	19a. Informant's Name/Relationship (Ty	pe, Print)			and Number or Ri	ural Route Nun	nber, City or		
ย์	Pages 1 and nent of Health int: If Item 27 iry or other t		Barry Scherr/son 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 ☒ Donation 5 □ Other (Specify)	+ ,	29 Wi Place of Disposition cemetery, crematory	(Name of	d Court	Baltimo Date	20c. Lo	2120 cation · City or	Town, State
Dalt	permit. Pages Department of I Important: If Ite sny injury or o once.		21. Signature of Funeral Service License Roylald S. J	Jad irecto	r State Balt	e Anat imore,	oss of Facility Comy Boar MD 212	đ 655 W	. Bal	timore	Street
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.	HENT		ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
36	/Medical Examiner	er	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consection). Due to (or as a consection).	MATC	010	ARTI	HRIT	15	_	monetto
,00,	te be executed ysician and te burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect	quence of):						
O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely tilled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 Ector	pic pregnancer (specify)	у		_	23d. Date of de Month	livery Day Year
ds, P	ulres that signed b Id be deta	þ	Part II. Other significant conditions con	ntributing to death but not re	sulting in the underly	ring cause gr	van in Part I.			se contribute to	o the cause of death?
of Vital Records,	The law require rate has been sin page 2 should t	Completed						pe	as an itopsy orformed? s 2 No	24b. Were at prior to death?	utopsy findings available completion of cause of 2 DNo
Vita	ysician: is certific director,	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3[DOA Ct	26. Place of De			6 □Other (Spe	ecify)
ion of	anding Phy lath. or: After this		27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Descrit	oe how injur	y occurred	
Division	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely tilled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Spec	city)			City or	Town, State)	ural Route Number,
	n 24 hou	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my kr iner: On the basis of examin and manner stated.	nowledge, death occi nation and/or investig	urred at the t pation, in my	ime, date and plac opinion, death occ	e, and due to to curred at the tin	ne, date and	I place, and du	e to the cause(s)
	Totl withi Totl	W	29b. Signature and title of certifier Sympathy 30. Name and address of person who c	ompleted cause of death (is	em 23a) (Tune Print)		OS31	50		B 160	(h, Day, Year) TO ZCC 6 I C MD YBIA 2104
	St	ate	31. Date filed (Month, Day, Year)	. 4		SAN	TIAGO	ROA	D C	0000	4BIA 2104

			For State Registrar	State of Maryla		artment of Healt rtificate of Dea			ene g. No. ()		057	56
	D		1. Decedent's Name (First, Middle, L.	ast)				2. Date of Death Month	Day	Year	3. Time of	Death
	Physicia /Medic		Raymond F.	Stone, Sr.		,		EBRUAR	-	2006	5:00	PM
	Examin	er	4a. Fecility Name (If not institution, gi		do	4b. City, Town, or Locati		h. 8045.	4c. Coun	ty of Death		
			Saint Joseph			If Under 1 Year If Un	TOWS O	8. Date of Birth	ļ	-	imore	
	Funeral Director			Sex 7. Age (In yi	rs. last birthday) Yrs.	Months Days Hou		July 3,	^{Year)} 1925	Miss	lace (State o	or r-oreign
			Usual Residence of Decedent	Λ 00				dury o,	1723	1111000	2011	
	nylan how		10a. State 10b. County	10c.	City, Town or Lo	ocation				1	0d. Inside Ci	•
	e Ma	cto	Maryland Baltimo	ore T	owson						1 TYes	2XIN0
	or 28	Dire	10e. Street and Number			10f. Zip Code		10		f What Coun	try?	
	s 23a	ral	1 Southerly Cou	12. Was Decedent Ever in	118 12	21286	Origin? /Sno	poity Voc or No-	USA	ace - Americ	an Indian	
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "neturel", or items 23a or 28a-f show marked other then "neturel", in the safe to the indifficult and the redifficult at	by Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces?		Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes		Rican, etc.)		ack, White,		
Maryland 21215-0036	2 hou	ted	15. Decedent's B	Education	16a. Dece	dent's Usual Occupation			6b. Kind of	Business/Ind	dustry	
215	hin 7. 9. Medi	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	life.	kind of work done during a DO NOT use retired)	most of workii	ng				
2	ad wit	Con		4	Re	gional Vice					edit I	ndem.
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las			18. M		(First, Middle, N				
<u> </u>	should and Men s marke umatic	ဥ	August Frank	Stone	401-14-75	111 (2)	Mae	Norma		smeye		
Mai	2 8 8	6 1	19a. Informant's Name/Relationship Raymond F. Stone			ng Address <i>(Street and Nu</i> Forest Hill		noute Number. Wilkest	•			
	1 and 2 Health em 27	1 1	20a. Method of Disposition		o. Place of Dispo	osition (Name of	_			n - City or To		
altimore,	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 🔀 Other (Spec	Removal from State	•	matory`or other place) Valley Mausc	2/24	/06	Cimoni	um, Mo	4	
≣			21. Signatural Funer Service Lice			2. Name and Address of F.		, 00			ck Roa	d
ñ	permit. Departr Importe eny inju		1501	10/1	R	uck Towson F	uneral	Home, I				
			23a. Part1. Enter the disease, or conshock, or heart failure. List on	polications that caused the devone cause on each line.	eath. Do not en	ter the mode of dying, such	h as cardiac o	r respiratory arre	st,		Approximat Interval Bet	ween
	Pnysician :		Immediate Cause (Final disease or condition	a. RESPIRAT							Onset and I	Death
	/Medical Examiner		resulting in death)	Due to (or as a cons		LLUNE						
	Examine	_	Sequentially list conditions, if any, leading to immediate	b. PNEUMONI								
\rd	ed isit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	- Juence on							
-	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):							
8760,	ate hy:	lical		d RENAL FA	ILURE							
Box 6	eath certific attending p I for use as I	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. [ate of delive	ary	
.O. Bc	the hed	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1□Live birth 2 □ F 4□Pregnant at time o 9□ Unknown		Dectopic pregnancy Other (specify)				Month		Year
۵.	res that th igned by be detac		Part II. Other significant conditions	contributing to death but not	resulting in the t	ınderlying cause given in P	Part I.	23e. Did tob	acco use co	ntribute to th	ne cause of c	death?
rds	quires in sign	ed by	LACTIC ACIDOSIS					1 🗆 Ye	s 200 No	3 🗌 Prob	ably 4 🗆	Unknown
00	law requir as been si 2 should	Completed	CHRONIC OBSTRUCT	IVE PULMONARY	DISEAS	E		24a. Was ar		. Were auto	psy findings	available
æ	hysicien: The lav nis certificate has I director, page 2	E	DEEP VENOUS THRO					autops perform		death?	mpletion of c	ause of
ţ		Be C	25. Was case referred to medical examiner?			26. F	Place of Death	(Check only on	9)			
Ž	Physic this ce al dire	To	1 ☐ Yes 2 No		ER/Outpatie			me 5 🗌 Reside			v)	
ū	Attending Physicien: r death. ector: After this certification the funeral director.	on:	27. Manner of Dath 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Work?		28d. Describe ho	w injury occ	urred		
Sio	or Attending after death. Director: After in by the funer	icat	Accident investigati		t home form at	M 1 Yes		28f. Location (Sti	reet and Nu	nher or Rura	I Route Nur	her
Division of Vital Records,	after Direction by	Certification:	4 Homicide determine	building, etc. (Spe	ecity)	reet, factory, office		City or Town	. State)	11001 07 11010	771001071071	1501,
_	Hospite 4 hours Funerel ely fillec	edical C	29a. Certifier (Check only one) Certifying I	Physician: To the best of my laminer: On the basis of examend and manner stated.	knowledge, dea ination and/or in	th occurred at the time, dat ovestigation, in my opinion,	te and place, a , death occurr	and due to the ca ed at the time, da	use(s) and i	manner as si e, and due to	ated. the cause(s	5)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	, ,) W	29c. License numi	ber	29	d. Date sign	ned (Manth,	Day, Year)	
	. , , , ,		Richard	iL. Lint	Tichu		D Z.		2-2	21-8	X.	
	30+1		30. Name and address of person wh	o completed cause of death (I	Item 23a) (Type							
	2011			NTLITCIN M. T	720	OSLER DR	I UE- 1' 6	OWSON M	APVI (ann :	1204	
	Sta		31 Date filed (Month, Day, Year)	32 Fegistrar's Si		4	as.¥fam. I‰	at 1/14 hard Novel 3 74 \$*;	17 1 1 Jun 1	21 Th/ lim	ote from Lat	
UH	Registr		FEB 2 7	2006	Sto St	parks						

			1 - For State of Mar Registrar	ryland / Depa	artment of F			ene 006	05757
	Physicia	an	Decedent's Name (First, Middle, Last) A. Thomas Strand				2. Date of Death	y ^{Day} 24, 200	3. Time of Death 7:30 A M
	/Medic	al	4a. Facility Name (If not institution, give street and number)		4b. City. Town, o	r Location of Death		4c. County of Dea	
	Examin	er	406 Kilree Road # 102		Luthery			Baltimo	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth	9. Bi	rthplace (State or Foreign country)
	Director			36 Yrs.	World's Days	TIOUIS WIII.	09/24/1	919	N.D.
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	daryii f eho	JO.	MD Baltimore	Lutherv	ille				1 ☐ Yes 2 🖔 No
	28a	reci	10e. Street and Number	Ed Circi V	10f. Zip Code		10g	. Citizen of What C	country?
	h with	Funeral Director	406 Kilree Road # 102		2109	93		USA	
	deat	ner	11. Marital Status 12. Was Decedent Ev Amped Forces?	rer in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race - Am Black, Wh	
0	or it	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 1 1 1 1	1 ☐ Yes 2 🛣 No	Specify:	,	Specify: Wh	
2-0030	tural'		3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a Decer	dent's Usual Occup	nation	16	b. Kind of Busines	s/ladustry
'n	in 72 n° n	Completed	(Specify only highest grade completed)	(Give	kind of work done DO NOT use retire	during most of work	king	D. Raile of Besilios.	a modeli y
7	d with giene.	mo	Elementary/Secondary (0·12) Collega (1-4or 5+)	['] Mec	hanical	Engineer		DuPont	Company
ם פ	al Hyg	Be C	17. Father's Name (First, Middle, Last)				ne (First, Middle, Ma		
yıand	Menta Menta arked atic e	Tof	Albert C. Strand			Mary			
Mar	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28a-f ehow other traumatic event, the Medical Examinatinual Lanixilliad at		19a. Informant's Name/Relationship (Type, Print) John Strand/son				ral Route Number, C ISOn, Mary		Zip Code) 204
e û	1 and 1ealth 9m 27 ther t	l d	20a. Method of Disposition	20b. Place of Dispo		Ave. 10W		c. Location - City o	
	ages nt of t		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Hilltop	matory or other pla		7/2006		Maryland
Dailimor	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other ances.		4 □ Denation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee						Home, Inc.
n	Depa Impo any i		Stephen Cost				wson, Mar		1204
h			23a.Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	he death. Do not ent					Approximate Interval Between
	Physician	i n		iciuse 1	Fance	LATI 021			Onset and Death
	/Medical		resulting in death)						77,700
	Examiner		Sequentially list conditions, if any, leading to immediate Due to (or as a Due to (or as a Due to (or as a	(TRITEM)	/FACLU	128 70	THRIVE.		E WERKS
iL	be is	Examiner	cause. Enter Underlying		9				1 minus
P	be executed Ician and burial-transit	хап	that initiated events	consequence of):					powin
2/00/2	ate be executed hysician and the burial-transit	<u> </u>							
200	certificate iding phys	edlc	d.						
X Q Q	leath certifica attending ph for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2		Ectopic pregnanc			23d. Date of d	,
	death e atten	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at ti		Other (specify)	,		Month	Day Year
r S	at the d by the etache	Phy	9 Unknown	The state of			02a Did taba		to the course of death?
Š,	n requires that the deben signed by the should be detached	þ	Part II. Other significant conditions contributing to death but	-		CRONIC		./	to the cause of death? Probably 4 Unknown
cord	requi	eted	ANGMIA, PEZIDHERMI		-				
Ç Ç	The law ste has b	Completed	KIDNEY DISEASE, MYPE	ETENSIC	on,		24a. Was an autopsy performe	prior to death?	
<u></u>		ဝင္	25. Was case referred to medical			OC Olege of Dag	1 ☐ Yes 2 ☐	No 1□Ye	es 2 No
VII	Physician: this certific ral director,	o B	examiner? 1 Yes 2 No Hospital: 1 Inpatient	t 2 ER/Outpatier	nt 3 DOA Ott		ome 5 Residen	ce 6 □Other (St	pecify)
10	D 0 0	lon; T	27. Mannar of Death 28a. Date of Injury	28b. Time of			28d. Describe how		
0	Attending r death. sctor: Afte	atlo	2 Accident investigation	, , , , , , , , , , , , , , , , , , , ,]Yes 2□No			
DIVISION	r Atter de irecte	Certificat	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur building, etc.	ry - At home, farm, str (Specify)	reet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
2	urs af urs af orai D	Ce							
	Hosp 24 ho Fune stely f	edicai	29a. Certifier 1	examination and/or in					
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	Me	29b. Signature and title of certifier		29c. Licens			d. Date signed (Mor	
)	->-0		19 = 4/1	-mo	0:	53095	F3	BRUSEY	24.2006
	/ 1_ i		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type,	Print)_				24,2006
	611		ERIC J. Corr, um	12221	Tucam	nore Ro	. Timon	seem my	21093
	Sta Registr		31. Date filed (Month, Day, Year) 31. Registrar	's Signature	wei				
90	•			- 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Las 2. Date of Death Day **Physician** Year 2330M 24 2006 MATHAN æ /Medical . Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner (BAlto WASh olew Burnia If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1XM 2□ F Yrs. Director 18 214-21-6611 February .1988 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinational be notified at Marvland Anne Arundel Pasadena 1 Tyes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 South Carolina Avenue 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) High School Student permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event. 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kenneth Brian Sekinger Sara Catherine Sneeringer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21122 Sara C. Sekinger (Mother) 109 South Carolina Avenue, Pasadena, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bavview Crematory 03-02-06 Baltimore, Maryland ' 4 □ Donation 5 □ Other (Specify) 2 Name and Address of Facility Coully-Polyniak Funcral Home P.A. 3204 Mountain koad, Fasadena, Maryla<u>nd 21122</u> 21. Signature of Funeral Service Licenses 23.1 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria by Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
11 Yes 2 □ No completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Describe how injury occurred
Auto collision 27. Manner of Death 28b. Time of Injury After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 TNo 2243 death. Accident Director: Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, n) or Town, State) lace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire MOUNTAIN KOAd 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certified Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier m rson who comple ed ca e of death (Item 23a) (Type res MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

			For State	#State Poh	laryland	d / Depa	artmen	t of H	ealth a	and Me		iene	0.6		759
			Registramend Ttel 1. Decedent's Name (First, Middle	n #16b Per	ANA B	D G85	C'EFE	1700	' 9н '''		2. Date of Dea	eg. No.		3. Tir	ne of Death
	Physici /Medi		Gregori	, Spence							Heb Teb	20	200	6 0	743 AM
	Examir		4a. Facility Name (If not Institution		r)	7.	4b. City,	Town, or	Location	of Death			ounty of Dea		
			HCGH				a	olu	nbi	a		1	lowar	rd	
	Funeral		5. Social Security Number	6. Sex 7. 7 1 ☑ M 2 ☐ F	Age (In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	B. Date of Birth (Month, Day	Year)	9. Bii	thplace (Si ountry)	ate or Foreign
	Director		546-70-5762 Usual Residence of Decedent	- X	59	115.		1			Feb 9,	1947	Cal:	lforn	ia
	yland iow		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Insi	de City Limits
	Mar se	io	MD Howar	d	-61	arksb	urg	C.	lark	sville	2			1 🗆	Yes 2√No
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Itam 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examinat must be notified at	by Funeral Director	10e. Street and Number 6821 Maiden I	ane			10f. Zip	Code	2102	29	1	_	n of What C	ountry?	
	deati	ner	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S	3. 13.	Was Deced	lent of His	spanic Or	rigin? (Spec	ify Yes or No- ican, etc.)	14.	Race - Am		in,
98	or It	y Fu	1 ☐ Never Married 2 Married	ied 1 ☐ Yes 2 €			1 ☐ Yes 2		Specify:		ican, etc.,	S	Black, Whi	white	
21215-0036	hours ural',	d b	3 Widowed 4 Divorced	Year or Dates	i:						-				
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	il Hygid other	Be C	17. Father's Name (First, Middle,	Last)						er's Name	First, Middle,			OVELL	
/lar	should be nd Mental rmarked c	To E	Glenn Malcon	Spencer					Ber	nice	Gregory	7			
Maryland	2 sho and ! is ms		19a. Informant's Name/Relations								œvilde			Zip Code)	
	1 and Health am 27 Ither tr		Maura J. Conle	y/spouse	1				ane		sburg,		21029		
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (S		1 00	ace of Dispo metery, crer	nsition (Nan matory or o	ne of ther place	9)	Da	te	20c. Loca	tion - City o	Town, Sta	te
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Ronald	Licensee S. Wade, 711	ector	St	Name and Altimo	nato	my B	oard 21201	655 W.	Balt	imore	Stre	et
	100		23a. Pa 1. Enter the dis se, show, or heart failure. List	complications that caus	ed the death					The second second second second	respiratory arr	est,		Approx	imate l Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Hy	POXIA									Onset	and Death
8	Examiner	١.	Sequentially list conditions,	b. Ven	tricul	av Ta	ehyc	eurdi	0						
	nsit	Examiner	Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury	Hu	naerk	00,44	Co								
Ć,	execution and an ital-tr	Exa	that initiated events resulting in death) Last	c. Due to (or	s a consequ	ence of):									
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Records, P.	quires that n signed b uld be deta	b	Part II. Other significant condition	ons contributing to death	but not resu	iting in the u	nderlying ca	ause give	n in Part I	1.		bacco use	contribute t		of death?
00	aw requir s been s 2 should	olet									24a. Was a		24b. Were a	utopsy find	ings available
R	The lav	Completed									autops perform	med?	death?	completion 2 No	of cause of
Vital	ilcian: Th certificate rector, pag	Bec	25. Was case referred to medica						26. Place	e of Death	Check only or			, 2010	
of V	Physician: this certifica ral director, p	70	examiner? 1 🗌 Yes 2 No	Hospital: 1 ☐ Inpa		ER/Outpatier	nt 3 🗆 DO	Othe	r: 4□NL	ursing Hom	e 5 🗆 Reside	ence 6[Other (Spe	ecify)	
טע		on:	27. Manner of Death 1 X Natural 5 ☐ Pendir	28a. Date of In (Month, D	jury Day Year)	28b. Time of Injury		8c. Injury Work			ld. Describe ho	ow injury o	occurred		
Sio	uttandil death. ctor: Al y the fu	cati	2 Accident investig	ant ha			М		'es 2 🗆	No					
Division	Ital or A	Certification:	4 Homicide determ	ined 288. Place of I	etc. (Specify)	ne, iarm, str	eet, factory	r, office		28	If. Location (Si City or Town		vumber or h	urai Houte	Number,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1 Certifyir (Check only one) 2 Medicel	g Physicien: To the bes Examiner: On the basis and manner:	of examinati	vledge, deatl on and/or in	h occurred a vestigation,	at the time in my op	e, date ar inion, dea	nd place, ar ath occurred	d due to the c d at the time, d	ause(s) ar ate and pl	id manner a ace, and du	s stated. e to the car	use(s)
	To t To t	Σ	29b. Signature and title of certifie	-0				. License			2	9d. Date s	signed (Mon	th, Day, Ye	ar)
•			1 Druge	I MO				009	717	7		teb	20	, 2c	206
_			30. Name and address of person Evan Allen E	who completed cause of	tcht	1 (Print)	bia	, MD)					
	Sta	3	31. Date filed (Month, Day, Year)	J 32. Regis	trar's Signati	ure	. 00 -		,						
	Registr	ar	FEB 2 7	2006 Marie	J 15	of the same									

			1 - For State Registrar	State of Maryland	/ Department of H		ntal Hygien	IIII I)5760
	Physici		Decedent's Name (First, Middle, Last)	Evelyn	Steven	2.	Date of Death Month Date Powery		3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give s S +	treet and number) h Nursing (lenter 13	or Location of Death Althory If Under 24 Hrs. Hours Min. 8.	1 40	c. County of Death 9. Birthp	place (State or Foreign
	laryland ehow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				Od. Inside City Limits
	th with the Ma 23a or 28a-fe ust be netified	irector	Maryland 10e. Street and Number	Balt	imore 10f. Zip Code		10g. C	itizen of What Cour	1 ☑ Yes 2 □ No ntry?
9000	urs after dea ai', or items	d by Funeral Director	3300 Benson Avenue 11. Marital Status 1 □ Never Married 2 □ Married 3 双 Widowed 4 □ Divorced	Apt430 12. Was Decedent Ever in U.S. Armed Forces? 1		227 dispanic Origin? (Specif an, Mexican, Puerto Ric Specify:	USA y Yes or No- ean, etc.)	14. Race - Americ Black, White, Specify: Whit	etc.
21215-0036	s 1 and 2 should be filed within 72 hc if Heelth and Mental Hygiene. item 27 ie marked other than "natur other traumatic event, Ite M. Alfall	Completed	15. Decedent's Educition (Specify only highest grade Elementary/Secondary (0-12)	cation o completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working	16b. I	Kind of Business/In	dustry
	should be filed withir of Mental Hygiene. marked other than matic event, Ine Mental Hygiene.	Be	12 17. Father's Name (First, Middle, Last)		Homemaker	18. Mother's Name (F		wn Home n Surname)	
Maryland	2 should be and Mental ie marked o aumatic eve	2	Charles Powell 19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailing Address (Street	Ellen He		or Town, State, Zip	Code)
Baltimore, Ma	t. Page nment o rtant: if njury or		Shelly Buhlman 20a. Method of Disposition 1 Burial 2 Scremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	emoval from State Metr	ce of Disposition (Name of netery, crematory or other place or Crematory	^{Date} 2/25/20)06 Bal	Location - City or To	own, State faryland
8	Depa Impo		23a. Part1. Enter the disease, or compli	cations that caused the death	Funeral H 1630 Edmo	ome of Cato ndson Avenu	onsville, ie; Caton	Inc. sville, M	TD 21228 Approximate
W.	Physician /Medical Examiner	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	e cause on each line.	atic carc	-			Interval Between Onset and Death MWN MJ
8760,	cate be executed ohysicien and the burial-transit	dicai Exar	that initiated events resulting in death) Last	Due to (or as a conseque	ince of):				
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	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	ospital: 1 ☐ Inpatient 2 ☐ El	R/Outpatient 3 DOA Oth	26. Place of Death (C		6 ☐Other (Specifi	v)
ion of	After fune	ation; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of 28c. Injury Wor	ry at 28d	d. Describe how inju		
Division	s ofter death	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office	28f	. Location (Street a City or Town, Stat	and Number or Rura te)	il Route Number,
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ì	To the within to the complete	M	29b. Signature and title of certifier	mmo	29c. Licens	se number (-2 9)	29d. D	ate signed (Month,	
	3		30. Name and address of person who co	malatad cause of death /Itam S	(3a) (Type, Print)	altimore	. Mr.	ry land	24,2006
	Sta Registr		31. Date filed (Morth, Day, Year)	32:Registrar's Signatu	re for the first	10111111111	. , , , , , , ,	y wind	LILL

			_ FOI	of Maryland / Department of Health and Ment	al Hygiene nns n5761
			State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No. ate of Death 3. Time of Death
	Physicia /Medic	al .	Eric 4a, Facility Name (I) not institution, give street and	Smith Fe	Sonth Day Year ()' / Co
	Examin	er	Joseph Ritchie	Hospice Baltimore	NA
Ī	Funeral Director		5. Social Security Number 6. Sex 12/M 2		9. Birthplace (State or Foreign Country) 7. 31,1958 New York
	vland ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
	h the Marylan r 28a-f ehow Lostified at	ctor	MD NIA	2903 W. Mosher St.	1, Nes 2 □ No
	ter death with the last 23e or 2 lines count be as	Funeral Director	2903 W. Moshe		10g. Citizen of What Country?
036	urs after dea al', or Items Exament on	δ	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. If Forces? If Yes, specify Cuban, Mexican, Puerto Rican es 2 No Give or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican es 2 No Specify:	(es or No- h, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Ital Hygiene. od other than "natural", or Items 23s or 28s-1 show event, the Mudical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade complete) Elementary/Secondary (0-12) Collect	ed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 55CURIN OFFICER	16b. Kind of Business/Industry GECURITY
land 2	s 1 and 2 should be filed within I Health and Mental Hygiene Item 27 is marked other than other treumatic event. ITEM	To Be C	17. Father's Name (First, Middle, Last) MOTTHEW SCOTT		st, Middle, Maiden Surname)
Mary	and 2 should ealth and Men m 27 is marke her treumatic		Shan Fiea Smith - C	19b. Mailing Address (Street and Number or Rural Rou MUNDR AVE. Apt.	/
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If Item 27 it any injury or other tre		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal fit 4 □ Donation / 3 □ Other (Specify)	om State 20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Cemetery 2-27	20c. Location - City or Town, State -06 Dunca k mb
Balti	permit. Departm Importa any inju		21. Signature of Fineral Service Jicense	22. Name and Ad ress of Facility	edhilten Pass Balto MO 21929
	Physician		Immediate Cause (Final	nat caused the death. Do not enter the mode of dying, such as cardiac or respon each line.	piratory arrest, Approximate Interval Between Onset and Death
2	/Medical Examiner		resulting in death)	to (or as a consequence of):	
26	uted	Examiner	Sequentially list conditions. Tariy, learning to anni ediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	o to (or as a consequence of):	
760.	te be executed ysicien and he buriel-transit	cal Exa		e to (or as a consequence of):	
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0,00	that the dea ed by the at detached fo	hysici	9 Unknown 9 U	regnant at time of death 5 \sum Other (specify)	
S, I spr	v requires tha been signed should be del	ed by	(ostible Maningt 11 1/30/2006-ALL STUDIO	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
$C_{m}H \to S_{m}$	sician: The law re certificate hes be irector, page 2 sh	Completed by Physician/M	H		24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
/ \tau_	ician: certific	Be	25. Was case referred to medical examiner?	26. Place of Death Ch	
Sm/H	ding Phys I. After this funeral dii	n: To	27. Manner of Death 28a. D		5 Residence 6 DOther (Specify)
, isi	Attendir r death. ector: Af by the fu	catic	2 Accident investigation 3 Suicide 6 Could not be	M 1 Tes 2 No	ocation (Street and Number or Rural Route Number,
\$ C.	tal or A s after al Direct	Certif	4 Homicide determined 288.		City or Town, State)
T	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical Certification:	(Check only 2 Medical Exeminer: On t	o the best of my knowledge, death occurred at the time, date and place, and d he basis of examination and/or investigation, in my opinion, death occurred at manner stated.	the time, date and place, and due to the cause(s)
	Tot Tot	Σ	29b. Signature and title of certifier	29c. License number D 41476	29d. Date signed (Month, Day, Year) 02.19.2006
	文		30. Name and address of person who completed RAYMOND WILLSON M.D		Himme, MD 21204
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 7 2006	2 Registrar's Signature	

			1 - For State Registrar	State of N	Marylan		artmen			and Me		jiene	06	1576	12
K			Decedent's Name (First, Middle, La	st)				0 01 2		1:	2. Date of Dear		APPL APPL	3. Time of D	Death
	Physicia		MABEL	SHERM	441	/					Month ES	21 a	Year 2006	6.30	
	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City,	Town, or	Location o		103	~ .	inty of Death	0 0	
	± Admin		GENESIS ELDERCAF			ENTER		BROC	KLANI	OVILL	E	ВА	LTIMOR	E	
	Funeral		5. Social Security Number 6. S	Sex 7. /		last birthday)	If Under	1 Year	If Under	24 Hrs. 8	B. Date of Birth (Month, Day			ace (State or	Foreign
	Director		213-52-6149	□M 2F	96	Yrs.	Months	Days	Hours	Min.	9/19/19			SYLVAN	ТΔ
7	2 .		Usual Residence of Decedent			y. Town or Lo					71 171 17				
-	show dat	_	10a. State 10b. County		TOC. CIE								'	0d. Inside City 1 ☐ Yes 2	
7	89-4	Director	MD BALTI	.MORE		PARKV									7
467	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Ē	10e. Street and Number				10f. Zip				'		of What Coun	try ?	
4	9 23 m	Funeral	2523 TAYLOR AVEN	IUE 12. Was Deceder	at Ever in II	C 12.1	Mac Doon	2123		rin? (Space	atu Vac ar Na	US	A Race - Americ	an Indian	
Ť	Item Item	in un	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Force	s?	.5.	f Yes, spe	city Cubar	n, Mexican	, Puerto R	ofy Yes or No- lican, etc.)	14.	Black, White,		
2	l', or	by F	3 ₩ Widowed 4 Divorced	If Yes, Give		'	1 🗆 Yes	2 X No	Specify:			Spe	ecify:	ITE	
5	illed within 7.2 flours after death with the maryland Hygiene. Ither than "neturel", or Iteme 23a or 28a-f show ent, tre Mississa Evantinet must be notified at		15. Decedent's E			16a. Deced	ient's Usu	al Occupa	tion			16b. Kind o	of Business/Inc		-
2 1	West 1	ple	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4o	r 5±)	(Give life. L	kind of wo DO NOT u	rk done d se retired,	luring most)	t of working	9				
7	giene pr tha	Completed	_			HOM	IEMAKI	ER				OW	IN HOME		
2	~ ~ ~ ~	Be	8TH GRADE 17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle,	Maiden Sun	name)		
<u> </u>	inould be id Mental marked c matic eve	2	JAMES SWIGERT							SARA	H MORRI	ESON			
0	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic	ľ	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	(Street a	ind Numbe	r or Rural	Route Number	r, City or To	wn, State, Zip	Code)	
2	and ealth m 27 her tr		FRANCIS M. SHERN	IAN, JR./S					VENU		LTIMORE	E, MD	21234		
ָט ה	of Hea of Hea f Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from Stat	0	Place of Dispo cometery, crem	natory or o	ther place		Da			on - City or To		
	permit. Pages Department of Importent: If II ony injury or one		4 Donation 5 Other (Special		MOR	RELAND	MEM.	PARK		3/2/2	.006	HILLE	ENDALE,	MD	
=	partir poort y inj		21. Signature of Funeral Service Lice	1500		22	. Name ar	nd Addres	s of Facilit	y THE	JOHNSO	ON FUN	IERAL H	OME, P	.A.
Ω :	80E 5 8		1/2			8	521 I	COCH	RAVE	N BLV	D. TOWS	SON, M	D 212	86	
			23a Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caus	ed the deat	h. Do not ent	er the mod	te of dying	g, such as	cardiac or	respiratory arr	est,		Approximate Interval Between	een
P	hysician		Immediate Cause (Final disease or condition	Kai	118	E T	0	CHA	1100				de	Onset and De	∍ath
	/Medical		resulting in death)		as a conseq				(C	75	
E	Examiner		Sequentially list conditions	b. de	me	ntu	<u>_</u>							mone	Pi
7	D ##	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	as a conseq			1		1	0				
9	and Ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. <u>Co</u>			ar	ter	4	avo:	ears	2	- 4	ear	2
,00,	ate be executed hysicien and he burial-transit	Ě	resulting in death) Last	Due to (or a	as a conseq	uence on.									
	hysic the b	lical	•	d						-					
9	To the hospitel or attending Prysticien: The law requires that the death certifica within 24 because after death. Within 24 because after death. Completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE:	00-14											
S S	ath c liftend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1 ☐ Live birth	2 Feta	Ideath 3	Ectopic p					23d.	Date of delive Month	-	эаг
5	the a	/sic	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5∟	Other (sp	pecify)						,	
	nat it od by Jetac		Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying	ausa rive	n in Part I		23e. Did to	bacco use o	contribute to the	e cause of de	ath?
ń	signe d be	d by	, a, , , , , , , , , , , , , , , , , ,	g 10 00			, adding any	g.v.						ably 4 Dor	,
ecorus,	requ been hould	Completed													
ב ב	hast 62s	npl									24a. Was a autops perfor	sy	4b. Were auto prior to con death?	osy findings av npletion of cau	vailable use of
= -	rsicien: The law s certificate has b lirector, page 2 s	S									1 Yes		1 Yes	2 No	
A ICA	Sertifi	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only or				
5	this al dir	L L	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 🗆 Inpa		ER/Outpatien		DA Care			e 5 Reside			′)	
	After funer	lon	1 Natural 5 ☐ Pending		Day Year)	Injury	M	Work	rai ? Yes 2 □ i		bu. Describe III	ow injury oc	Carred		
VISION	death death stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be	e Oge Diese of	Injury - At he	ome farm str			103 2 🗀		8f. Location (S	treet and Ni	umber or Rura	l Route Numb	97
}	after Olice in by	Certification:	4 Homicide determined	building,	etc. (Specif	y)	eet, lacci	y, onice			City or Town	n, State)	5/1/OG G/ 1/10/0	Trobio rionio	01,
	To the Prospile or Attending Prystoten: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:		29a. Certifier 12 Certifying Pl	nysician: To the be	st of my kno	wledge, death	n occurred	at the tim	e date an	d place, ar	nd due to the c	ausa(s) and	l manner as s	aled	
-	24 h Fur etely	Medical	(Check only 2 Medical Examone)	miner: On the basis	of examina	ition and/or in	vestigation	i, in my op	oinion, dea	th occurre	d at the time, d	late and pla	ce, and due to	the cause(s)	
	o thi ithin ompl	₩	29b. Signature and title of certifier				29	c. License	number		2	9d. Date sig	gned (Month,	Dey, Year)	
,	2		> Sno	LeMD			0	000	53	150		FEB	220	d 200	6
ĵ			30. Name and address of person who	completed cause of	f death (Iten	n 23a) (Type	Print)		-			-		Dlaw	615
H			Shakunma	ile hu	0 J-e	965	505	an	tra	10	loac	1 &	ecte,	10 210	45
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regi	strar's Signa	ature	8					1			
	Registr	ar	FEB 2 7	2006	100 Cario - 1	S. of	1004	1							

		-	For Stata Registrar		State	of Ma	ıryland	•	irtment of F		d Men		giene leg. No.	006	0576	3
	140		Decedent's Name	(First, Middle	, Last)							ate of Dea			3. Time of Dea	ath
	Physicia /Medic		BOBBY	C 5	MITH	1						Month	23	2006		М
	Examin	er	4a. Facility Name (If r				UED	CTR	4b. City, Town, o	r Location of D MODE				ounty of Death		ity
	Funeral		5. Social Security Nur		6. Sex	7. Age		st birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. C	ate of Birtl Month, Day	1		place (State or Fo	reign
	Director		217-40-452	26	1√2 M 2□	F	61	Yrs.	Months Days	Hours I	De	-	194		h Caroli	
	and *		Usual Residence of D	10b. County			10c. City,	Town or Lo	cation						10d. Inside City Li	imits
	Maryl.	Ď	Maryland	Balti	more		Du	ndalk							1 ☐ Yes 2 🕅	Z] No
	r 28e	Director	10e. Street and Numb	ber					10f. Zip Code				10g. Citize	en of What Cou	ntry?	
	th with		3432 Sc	ollers	Point 1	Road			21222					U.S.A		
	r dee	Funeral	11. Marital Status			Decedent E d Forces?			Was Decedent of H f Yes, specify Cub	lispanic Origin an, Mexican, P	? (Specify Puerto Rica	Yes or No- n, etc.)	14	 Race - Ameri Black, White 		
36	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygians. is marked other than "natural; or items 23s or 28s-f show aumatic event, the Madical Examinar must be notified at	by F	1 Never Married		ed	d Forces? es 2 ☐ N Give or Dates:	"196 5		1□Yes 2□XNo	Specify:			5	Specify: W	hite	
Ş	2 hou atura ical E	ted		15. Decedent	's Education		1966	16a. Deced	dent's Usual Occup	pation	f working	1	16b. Kind	d of Business/li	ndustry	
215	thin 7 e. an "n	Completed	Elementary/Second		t grade comple Colle	ge (1-4or 5	+)	lite. I	kind of work done DO NOT use retire	d)	Working					
7	led wi		47 Februar No 1/5	Ti-a Adiodolo I	()	2		Fore	nan	18. Mother's	Name /Fir	st Middle			inless S	stee.
and	ntal H od otl	Be	17. Father's Name (F	-irst, Middie, i	Lasi)			Smi	th	Este		31, <i>1411</i> 3310,	790.0011 0	,	1son	
Maryland 21215-0036	should nd Me mark smatic	ဥ	19a. Informant's Nan	ne/Relationsh	nip (Type, Print)				ng Address (Street			ute Numbe	r, City or			
<u> </u>	elth a		Patsy Smi	ith	(Wife	<u>,</u>		3432	Sollers	Point	Road	Balti	more	. Marvl	and 2122	2
e,	of He of He ritsm	3	20a. Method of Dispo	sition			Cei	ace of Dispo metery, crer	sition (Name of natory or other pla	ce) F	Date ebrua			ation - City or T		-
Ĕ	Pag ment ant: i		4 Donation 5	5 ☐ Other (S	pecify)		Sacr		art of Je	$_{\perp}^{\mathrm{esus}}$	7,200	6		alk, Ma		
Baltimore,	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If Itam 27 is marked eny injury or other traumatic ex		21. Signature of Fun	ach!	C/ (K	me	di.		Name and Addrew Dabrov	lalk Av	re. Ba	1 timo	re			
			23a. Part1. Enter the shock, or heart	e disease, or failure. List	complications to	nat caused on each lin	the death.	Do not ent	er the mode of dyl	ng, such as ca	rdiac or res	spiratory ar	rest,		Approximate Interval Betwee Onset and Dea	en eth
	Physician		Immediate Cause (F disease or condition	inal					lopathy						3 DAY	5
	/Medical Examiner		resulting in death)		Du	e to (or as	a conseque	ence of):	hive Pula		N:c	0.0.				
		e	Sequentially list con- if any, leading to im- cause. Enter Under	ditions, nediate	bDu	e to (or as	a conseque	ence of):	INC PUM	rovary	1 1218	tase				
1	uted d ansit	Examiner	cause. Enter Underl Cause (Disease or in that initiated events	lying njury	S. P	NEU A e to (or as	1021	a								
o	eath certificate be executed ettending physicien and for use as the burial-transit	Ex	resulting in death) La	ast					0:00							
8760,	ate by	dicai			d(e	NON	any 1	Arten	y Disla	se						
9	certific ding p	/Me	IF FEMALE:		23c. If ves	s, outcome	of pregnan	icy					2:	3d. Date of deli	verv	
Вох	The lew requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	by Physician/Me	23b. Was decedent in the past 12 n 1 \(\text{Yes} \) 2 \(\text{D} \)	nonths?	4□F	ive birth regnant at			Ectopic pregnanc Other (specify) _	y				Month	Day Yea	r
o.	it the d by the tached	hysi	9 Unknown	7140	9□(Jnknown										
S, D	w requires that s been signed t should be det	ру Р	Part II. Other signific	cant condition	ons contributing	to death b	ut not resu	lting in the u	nderlying cause gi	ven in Part I.					the cause of deat	
ord	requir sen si nould	ted									-	-	res 2□			
Sec	has b	Completed									-	24a. Was autop perfo		24b. Were au prior to d death?	topsy findings ava ompletion of caus	ulable se of
alF			05.14/							00 81		1 Yes	28 No		2□ No	
₹	Physicien: this certific ral director,	To Be	examiner?		Hospital:	1 Minpatie	ent 2 🗆 E	ER/Outpatie	nt 3 DOA Ot	26. Place o her: 4 ☐ Nurs				☐Other (Spec	ufv)	
100	g Phy lerthi		27. Manner of Death			Date of Inju	rv	28b. Time o				Describe				
joi	Attending ir death. ector: Alter by the fune	atio	1 X Natural 2 ☐ Accident	5 Pendin investig	gation			, , ,		Yes 2 No						
Division of Vital Record	after de i Direct	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	inad 256. I	Place of Injouilding, et	ury - At hor c. <i>(Specify</i>	me, farm, st)	reet, factory, office		28f.	Location (: City or Tox			ral Route Number	r.
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	edical C	29a. Certifier (Check only one)	1⊠ Certifyin 2 Medical	Examiner: On	o the best the basis of manner sta	f examinati	vledge, deat ion and/or in	h occurred at the to exestigation, in my	ime, date and opinion, death	place, and occurred a	due to the it the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)	
	To th within To th compl	Me	29b. Signature and t	title of certifie	1	/			_	se number				signed (Mont)		
			16	olo	A Ist	M	ave	y	Kes.	-000				0019	3/06	
	10x1		30. Name and addre	DUH	who completed WEY M	cause of d	leath (Item (940)	23a) (Type, EASTE	Print) KN AVE.	BALTI	MORE	.MD	212	24		
		ate rar	31. Date filed (Mont	h, Day, Year)		32. Registr	ar's Signat	ure	berk							
	incgist		F	EB 2	2006	A Company	30	cr /								

			1- For State of Maryland / Dep. Ce	artment of Health and M rtificate of Death	ental Hygie	ZIIII	05764
	Physici /Medio		Decedent's Name (First, Middle, Last) TONY H. TURNER		2. Date of Death Month FEB. 24	Day 2006	3. Time of Death 12:55AM
	Examin	er	4a. Facility Name (If not institution, give street and number) FUTURECARE - OLD COURT	4b. City, Town, or Location of Death RANDALLSTOWN		4c. County of Death BALTIMO	RE
59	Funeral Director		5. Social Security Number 220-84-6646 Usual Residence of Decedent 6. Sex 1 M M 2 F 7. Age (In yrs. last birthday) 7 yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 07/16/1		place (State or Foreign htry) RYLAND
	Maryland -f show lied at	tor	10a. State 10b. County 10c. City, Town or Lo	ORE CITY			10d. Inside City Limits 1 Yes 2 No
	deeth with the Marylan ne 23a or 28e-f show hast be natified at	Funeral Director	10e. Street and Number 2911 GRANTLEY AVENUE	10f. Zip Code 21215	_	Citizen of What Cou	ntry?
036	hours after deeth with the Maryland ture!, or iteme 23a or 28e-f show al Extrainer, and be marified at	by	1 Never Married 2 Married 1 Mere Married 1 Mere Married 1 Mere Married 1 Mere Mere Mere Mere Mere Mere Mere Me	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puertol 1 ☐ Yes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	etc.
21215-0036	within 72 ene. than "na'	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 TH 15. Decedent's Education (Give (Give life) College (1-4or 5+) WARI	dent's Usual Occupation kind of work done during most of workil DO NOT use retired) EHOUSE TECHNICIA	ng	HE ARMOR	
yland ;	ould be filed Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) JAMES HOWARD TURNER		(First, Middle, Maid	den Sumame)	
Mary	d 2 sho h and 7 is mu treum			ng Address (Street and Number or Rura			,
ıtımore, I	Peges 1 and nent of Health int: if item 2 iry or other t		20a. Method of Disposition 1 Burial XX cremation 3 Removal from State	matory or other place)	ate 20c	Location - City or To	own, State
Balti	permit. Pege Department of Important: if eny injury or once.		21. Signature of Juneral Service Licensee		VELL FUN	ERAL HOM	E 21207
8/00,	Certificate be executed American and Caraminer and Carami	licai Examiner	23a. Pack Enter the dease, or complications that caused the deast. Do not en shipt, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	7515	r respiratory arrest,		Approximate Interval Between Onset and Death
O. Box 6	ath for u	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
ecords, P.	n requires that the death been signed by the etter should be detached for u	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	co use contribute to the	he cause of death?
икаі несо	The law ete hes t page 2 s	Completed			24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of
	Physician: this certifice ral director, p	To Be	25. Was case referred to medical examiner? 1 \[Yes 2 \in No \] Hospital: 1 \[Inpatient 2 \[ER/Outpatient \]	26. Place of Death		e 6 □Other (Specif	iv)
DIVISION OF	ding h. After fune		27. Manney of Death 1. Actural 5 Pending (Month, Day Year) 2 Accident investigation		28d. Describe how in		y)
ŠĬ	To the Hospitei or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, Si		
	To the Hosp within 24 hor To the Fune completely fi	Medicai	29a. Certifier (Check only one) Control one) Control one Control on	vestigation, in my opinion, death occurre	ed at the time, date	and place, and due to	the cause(s)
	7		29b. Signature and title of certifier	29c. License number	-39.	Date signed (Month,	Uay, Year)
/	2		30. Name and address of person who completed cares of death (Item 23a) (Type, 505 R NH A R O M - O	5311 OLD (OL	ILT RD,	RAMBALLS	10WN
	Sta Registr		31. Date filed (Month, Day, Year) September 1. Date filed (Month, Day, Year) 32. Registrar's Signature	ed .			ر د ۱۱ م
DH	MH 17 Rev 1/20	001					

		1 State	partment of Health and Nertificate of Death		ene 0 0	6 05765
y	75 viv	Registrer 1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physic		Mary Lee Temmink		February	^{Day} 21, 20	06 9:40 P M
/Med Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of	
		1507 Dunlora Road	Towson		Balt	imore
Funera	- 4	5. Social Security Number 6. Sex 7. Age (In yrs. iast birtho	Months Davs Hours Min.	8. Date of Birth (Month, Day,)	1926	9. Birthplace (State or Foreign Country) Maryland
Directo	ır	722-05-5270 80 Yrs		reb. 1,	1320	riar y ranu
yland		10a. State 10b. County 10c. City, Town of	r Location			10d. Inside City Limits
ith the Marylar or 28a-f ehow	ctor	Maryland Baltimore Towso				1 ☐ Yes 2 🂢 No
or 26	Dire	10e. Street and Number	10f. Zip Code	10	g. Citizen of W	
e 23e	era	1507 Dunlora Road 11 Marital Status 12. Was Decedent Ever in U.S.	21204	pecify Yes or No-		A. - American Indian,
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland hall Hygiene. d other than "neture!, or iteme 23a or 28a-f show event, his Madical Examinar must be notified at	y Funeral Director	1 ☐ Never Married 2 ☐ Marned 1 ☐ Yes 2 ☐ No	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert Yes 2 No Specify: 	o Rican, etc.)	Specify:	k, White, etc.
5-UUSO 72 hours at neturel', or	ed by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. D	acedent's Usual Occupation	1	6b, Kind of Bu	White siness/Industry
41.72 thin 72 and 100	Completed	1	ecedent's Usual Occupation Bive kind of work done during most of wor le. DO NOT use retired)	king		
d with giene	E	Elementary/Secondary (0-12) College (1-4or 5+) 4 Ir	terior Designer		Self Em	
al Hygin	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, M		е)
Taryland 2 should be fill and Mental H; is marked oth	ပ	Raymond C. Friedel	Beatri		oddy	State Zin Code)
Mar d 2 sh th and th and traum traum	N.	isa. Illismano nama nama nama nama nama nama nama	•	wson, Mar		21204
C = 64 F		20a Method of Disposition 20b. Place of D	isposition (Name of			City or Town, State
Pages nent of nut: If its		1 X Burial 2 □ Cremation 3 □ Removal from State St. J. 4 □ Donation 5 □ Other (Specify)	nn S Church	5-2006	Hydes	Maryland
로 발된관심	Ŕ	21. Signiture of Tunical Sarvice Licensee	Cemetery 2-2. 22. Name and Address of Facility Ru			
Dep m	ā	taul W Hagan	1050 York Road	Towson, I		
		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardia	or respiratory arre	st,	Approximate Interval Between Onset and Death
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/Medica Examine		Due to (or as a consequence of	20 000d			Bucais
	e .	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	:			
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. 0 00	lysl	1 Yes 2 No 9 Unknown				
IS, P res that signed b be deta	5 P	Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.	23e. Did tob	_/	ribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
cord: * require been signstoned to	ted			- AL	_	
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f Vital Roysicien: The is certificate had director, page	(a	25. Was case referred to medical	26. Place of De	ath Check only one		
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on of ding Ph After th funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) inj	ury Work?	28d. Describe ho	w injury occur	red
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Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Olecal		death occurred at the time, date and place for investigation, in my opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and ma ate and place,	anner as stated. and due to the cause(s)
To the within To the comple	N	29b. Signardre and title of certifier	MD 29c. License number	6 2	9d. Date signe	d (Month, Day, Year)
, ,			Anna Drieth	-0 CM		
10		30. Name and address of person who completed cause of death (Item 23a)	DAUTIM	SRE RE	MD	21204
	State istra	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sperte			

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** A M 22, February 2006 Vincent F. Tumminello 5:20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Towson Baltimore Manor Care Ruxton 8. Date of Birth (Month, Day, Year)
Jan. 14, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**X** M 2□ F 83 1923 Maryland Director 215-16-1262 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County rithen "natural", or items 23e or 28a-f ehow the Medical Examiner roust be notified at 1 Yes 2 No Md_{-} Baltimore Towson Direct 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 7001 N. Charles Street 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene.
Iom 27 is marked other then "natural", or ite ither traumatic event, the Mudical Examina. 1 XX es 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 ₩ Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chemist Beer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vincent Tumminello Cascio Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other train Mrs. Vicki Friesner/Daughter 70 Montvieu Court Cockeysville, Maryland 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

↑ ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Pages 1 Dulaney Valley Mem. Grd. 2/27/06 Timonium, Maryland * 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ement. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 2 100 certificate 1 Yes 2 Ho 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one. Hospital: 1 | Inpatient Other: 4 Thursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient ဥ 1 Yes 2 HO 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No n 24 hours after death he Funeral Director: / oletely filled in by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number H0054424 2-23-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Asadi 20 E. limonium, MO Cyrus 11 monium rd. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year February nma 30 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner horien Nursing + Rehabilitation CTR n/a 8. Date of Birth Feb 13, 1923 Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex. **Funeral** 1 □ M 2 1 F 219-16-9905 83 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23e or 28e-1 show any lijury or other traumatic event, If a Medical Examinar must be notified any ance. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No n/a Directo MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5009 Frankford Avenue 21206 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 □ Widowed 4 □ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert В. Campbell Delia 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Philip A. Hucht-nephew 4700 Sunbrook Ave., Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2√☐ Cremation 3 ☐ Removal from State 2/24/06 Towson, MD Hillton Service Corp * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MEN **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy ō Day 4☐Pregnant at time of death 5 Other (specify) detached 9☐ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 🗌 Yes a No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) ical Certification: To 1 Tyes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: A filled in by the fr 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 2- Marke ₽egistrar's Signature State Registrar

			Amend Item 23a p	er Dr., G8	aryland 2,02/2	27 70 6	artment of I dipb rtificate of	Health and I Death	Mental Hy	giene	5 0	5768
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Ī	Funeral Director				ge (In yrs. les	st birthdey) Yrs.	If Under 1 Year Months Days	Baltimo	8. Date of Bir (Month, Da	th ay, Year)		ace (State or Foreign
			Usuel Residence of Decedent	//	79				Aug 9,	1926	Mary	Land
	show		10a. Stete 10b. County		10c. City, 1	Town or Lo	ocation				10	Od. Inside City Limits
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5-0	72 hc	eted	15. Decedent's E (Specify only highest g	Education		16e. Dece	dent's Usual Occup	petion during most of wor	kina	16b. Kind of B	usiness/Ind	ustry
21215-0036	filed within Hygiene.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		y/domest	during most of word) 1C		privat	e hom	es
and	e d to b	Be	17. Fether's Neme (First, Middle, Las	t)			unk	18. Mother's Nar	ne (First, Middle	, Maiden Surnan	ne)	unk
Maryland	2 sh end end	То	19a. Informent's Name/Relationship R. Alexander/Dep			19b. Mailir	ng Address (Street	t and Number or Ru	ral Route Numb	er, City or Town	State, Zip	Code) unk
Baltimore,	Pages 1 and nent of Heelth set: If Item 27 ury or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☒ Other (Spec	□Removal from State	cem	ce of Disponetery, crem	osition (Name of matory or other pla	ce)	Date	20c. Location	City or Tox	wn, State
Balt	permit. Depertrimporta any Inje		21. Signature of Funeral Service Lice Ronald S.				Name and Addre tate Anat altimore,	ess of Fecility Comy Boar MD 212		. Baltim	ore S	treet
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				on MiD.	515 F	air	mount	Ave 8th	F1. E	Balto.	MD	21204
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FEBRUARY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Dooth	-s. No. 006 05770
	à		1. Decedent's Nama (First, Middle, Last)	2. Data of Deet Month	th 3. Tima of Death
	Physicia /Medic		John C. Van Horn	January	10 0000 0 10 11
	Examin		4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Locetion of Daath	4c. County of Deeth
		2.	Vantage House	Columbia	Howard
74-	Funeral		5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year Months Days	Hours Min. (Month, Day,	, Yaar) Country)
i.e	Director		315-03-4924	June 8	, 1919 Indiana
	pue *	-	Usual Rasidanca of Dacedant 10a. State 10b. County 10c. City, Town or Location		10d. Insida City Limits
	/anyt	5			1 ☐ Yas 2√ No
	the the	8	MD Howard Columbia 10e. Street and Number 10f. Zip Coda	1	l0g. Citizen of What Country?
	72 hours after death with the Marylend natural; or items 23s or 28s-f show dical Examiner must be notified at	Funeral Director	5400 Vantage Point Road #1209	21044	USA
	Jeath 1	era	11. Marital Status 12. Was Decadant Evar in U,S. 13. Was Decadant of	Hispanic Origin? (Specify Yas or No- ban, Mexican, Puarto Rican, atc.)	14. Race - Amarican Indian,
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5-0	72 hours after dea "natural', or items poical Examiner m	e e	15. Decedent's Education 16e. Dacedent's Usual Occu (Spacify only highast grade complated) (Give kind of work done	upation a during most of working ed)	16b. Kind of Business/Industry
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2	a filed withing Hygiene. other than			18. Mother's Name (First, Middle, I	engineering Maiden Surmama)
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Baltimore,	of of		1 Burial 2 Cremation 3 Ramoval from Stata 4 Donetion 5 Other (Specify)	ace)	
Ħ		ŀ		ress of Facility Doord 655	W. Baltimore Street
B	permit. Depertrimportu any injurite.		Ronald S. Wade, Director State A Baltimo	-	w. Baltimole Street
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I ale	Physician		shock or haart failure. List only one causa on each line.		Onsat and Death
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	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral	edicai	29a. Certifiar 1/2 Certifying Physicisn: To the best of my knowledge, daath occurred at the (Check only one) 1/2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	rime, date and place, and due to the or opinion, death occurred at the time, a	date and place, and due to the cause(s)
	ithin 2 the vmple	Med	29c. Lice	nsa number	29d. Date signed (Month, Day, Year)
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			30. Name and address of person who complated cause of death (Itam 23a) (Type, Print)	TU TUU	11208
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	Physicia	20	1. Decedent's Name (First, Middle, Last)						2	2. Date of Dea Month	Day	Year	3. Time o	
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	Funeral	-	5. Social Security Number 6. Sec	7. Age (In yrs. la	st birthday)	If Under	1 Year	If Under 2	4 Hrs.	B. Date of Birth (Month, Day	Year)		lace (State	or Foreign
	Director		2/9-12-6/36	^{™ 2} √ F 91	Yrs.	Months	Days	Hours	IVIII.	Jan 28	, 1915	Ohic)	
3	and W		Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Lo	cation						1	0d. Inside (City Limits
1	-fehc	to	MD Howard	E	licot	t City	У						1 ☐ Ye	s 2√ No
4	or 28a	lrec	10e. Street and Number			10f. Zip	Code	0.1	010	1	10g. Citizen of		itry?	
-	deeth with the maryland ims 23a or 28a-f show	Funeral Director	3626 Valley Road						042	# . W N .		USA	an Indian	
j	items items	une	11, Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 M No	5. 13.	Was Decede If Yes, spec	ent of His ify Cubar	spanic Orig n, Mexican,	Puerto R	ify Yes or No- ican, etc.)	Bla Bla	ack, White,		
030	hours after turel, or ite	by	3 ∰ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	X No	Specify:			Speci	₩ whi	te	
		Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	(Give	dent's Usual kind of wor	k done d	uring most	of working	g	16b. Kind of E	Business/In	dustry	
121	within 72 ene. then "na ha Medic	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT us					W.R.	Crana		
	e riled within al Hygiene. I other then " vent, ine Me		17. Father's Name (First, Middle, Last)		Sec	retar	y	18. Mother	r's Name	(First, Middle,				1
lan E	Aental Aental rked o tic eve	To Be	Harry Heffner					Ali	ce S	tillmar	1			
Maryland	2 should and Men ie marke sumatic		19a. Informant's Name/Relationship (T)							Route Numbe			Code)	
	es 1 and 2 should b of Health and Ments litem 27 ie marked r other traumatic e		Francis Riley/dau 20a. Method of Disposition		167 ace of Dispo			ds Dr:	ive M	liddlet ne	own D			
ם מ	Pages nent of I int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☑ Donation 5 ☐ Other (Specify)	Removal from State	metery, crei	matory or ot	her place	9)						
	permit. Pages Department of the important: If ite eny injury or of once.		21. Signature Funeral Service Licens Ronal Sy	1	S1	2. Name and tate A	d Addres	s of Facility	oard	655 W.	Baltin	nore S	Street	
			23a. Parl 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death		altimo					rest,		Approxim Interval B	ate etween
	nysician	0	Immediate Cause (Final disease or condition	Muno dema	ment	re 1	0/150	Base					Onset and	
1	/Medical Examiner		resulting in death)	a. Due to (or as a con equ	ence of):									
	LAdimine	Į.	Sequentially list conditions,	b. Due to (or as a consequ	ience of):									
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events											
ó	e be executed rsician and e burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):									
		dlcai		d										
9 X	The law requires that the death certifile attending in page 2 should be detached for use a: It	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		_					23d. D	ate of deliv	ery	
. Box	death e atte	iciai	in the past 12 m/onths? 1 ☐ Yes 2 MNo	1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown		□Ectopic pro □ Other (sp			<u>-</u>		N	Month	Day	Year
O	res that the de signed by the a be detached (Phys	9 Unknown		ultina ia tha .	andarh ing a		on in Part I		23a Did to	obacco use co	ntribute to t	he cause o	f death?
Š,	signer	by	Part II. Other significant conditions co	intributing to death but not rest	atang in the t	riderlying G	ause give	gii ni r cut i.		1 🗆 ነ	-		bably 4 [
Records,	w require been sig should b	etec								24a. Was	an 24b	. Were auto	opsy finding	s available
Re	The lavine has	Completed									rmed? 252/No	prior to co death? 1 \(\text{Yes}	mpletion of	cause of
Vital	ysician: The is certificate hadirector, page	Be C	25. Was case referred to medical examiner?							(Check only o	ne)			
	Physic this ce al dire	2	1 □ Yes 2 💆 No		ER/Outpatie					ne 5 K Resid			fy)	
uc	ding F	tlon:	27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	M	8c. Injun Work	k? Yes 2 ⊟≀		ou. Obscribe r	low injury occo	arrod		
Division of	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		me, farm, st	reet, factory	r, office		2	8f. Location (S City or Tov		nber or Rur	al Route No	umber,
_	To the Hospitel or within 24 hours afte To the Funerel Director completely filled in I	edical Ce	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of my kno liner: On the basis of examina	wiedge, dea tion and/or in	th occurred	at the tin	ne, date an	d place, a	and due to the	cause(s) and r	manner as :	stated.	ə (s)
	thin 24 the F the F mplete	Medi	one) 29b. Signature and title of certifier	and manner stated.				e number			29d. Date sign			
)	Z ¥ Z		255 Signature direction	11/16 M			0	660	1		Februa	arm	K	2006
			30. Name and address of person who		23a) (Type	, Print)	1 7 4	<u>-00<</u>	110	· · · · · · · · · · · · · · · · · · ·	^			
			GARY MILLOS	8186 Lan	- Bru	in Re	d.	日日	IKVIC	lge, M	1) :	2/075	>	
	St Regist	ate trar	31. Date filed (Month, Day, Year)	32. Pegistrar's Signa	ture A	BASE								

			For State Registrar	State of Ma	aryland	-	rtmen tificate				F	Reg. No.	0 (]6.	057	72
	Physici	an	1. Decedent's Name (First, Middle, Las	rt)							2. Date of Dea Month_	Day		Year	3. Time o	
	/Medic	72	-,W NHOC	T		1	41 011	_			1	1,	6	oc.	305	PM
	Examin	er	4a. Facility Name (If not institution, give		.1.			3	Location of		_		JA	of Death		
30.30		86	5. Social Security Number 6. S	MARY LAND		ast birthday)	If Under	1.0	If Under:		8 Date of Birt	h			place (State	or Foreign
188	Funeral Director			M 2□F	63	Yrs.	Months	Days	Hours	Min.	(Month, Day May 10	, Year) 194	12	Mary	land	or r c. c.g.r
	0		Usual Residence of Decedent													
	arylar how	_	MD 10b. County N/A			Town or Lo imore	cation							1	0d. Inside C	ity Limits
	he M.	Director			Dart.	THOLE	104 7:-	0.4.				10- Citi-		Min at Cause		
	a or 2	古	10e. Street and Number 1326 McHenry Stre	et			10f. Zip					U.S.A		What Cour	itry r	
	has 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13. V			spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)			e - Americ	an Indian,	
ယ	or Iter	필	1 ☐ Never Married 2 Narried	Armed Forces? 1 V Yes 2 ☐ If N s, Give		1					Rican, etc.)	1		ck, White,		
21215-0036	within 72 hours after death with the Maryland ane. Then "natural", or Items 23a or 28a-f ehow he Medical Examiner must be notified at	1 by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			Yes :	SEXTENO	Specify:				Specif	y: Whi	.te	
2-0	natu dical	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced (Give	lent's Usua kind of wo	al Occupa rk done d	ation <i>furing m</i> osi)	t of work	ing	16b. Kind	d of B	usiness/In	dustry	
121	within the me.	du	Elementary/Secondary (0-12)	College (1-4or	5+)	Secur					1	Secur	-i t-	17		
2	be filed within 72 hours after death with the Marylan be filed with Hygiene. do other than "natural", or flems 23a or 28a-f show event, the Medical Exeminat must be notified at		17. Father's Name (First, Middle, Last)		-	Bootar	10)			er's Name	e (First, Middle,		:			
an	should be filed withing the Mental Hygiene. marked other than imetic event, the Mi	To Be	John E. Witt, Sr.						Mary	Mar	ie Gomp	ertz				
<u></u>	2 should and Men is marke aumetic		19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailin	g Address	(Street a	and Numbe	er or Rura	al Route Numbe	r, City or	Town,	State, Zip	Code)	
	1 and 2 Health a lem 27 is		Geraldine Witt/Wi	fe				_	STre	et B	altimor	e MD	21	223		
ore	of He		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □	Removal from State	20b. Pla	ace of Dispo metery, cren	sition (Nan natory or o	ne of ther place	θ)		Date	20c. Loc	ation -	- City or To	own, State	
Ë	Pages tment of tant: If It jury or o		4 □Donation 5 □ Other (Specify)	Ho1	y Cros			-	3-3-	-			yn, M	D	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 is marke eny Injury or other traumetic 90.00.		21. Signature of Funeral Service Licen	I sau	allei	2	719 E	Iammo	nds 1	Ferr	me of La	ansdo)Wn(e e MD	21227	
			23a. Part . Enter the disease, or construction shock, or heart failure. List only	one cause on each li	habe death ne.	Do not ente	er the mod	e of dying	g, such as	cardiac o	or respiratory ar	rest,			Approxima Interval Be Onset and	tween
His	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Con	LONA	ruf	Aren	- Ky	D.	SEAS	5				0.100, 2.10	
	/Medical Examiner		7000ming in double,	Due to (or as	a consequ	ence of):		1								
b		er	Sequentially list conditions, if any, leading to immediate	b. Dua to (or se	a consequ	anca off:										
$\sqrt{}$	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c												
o,	be executed sician and burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):										
68760,	w - w	lical		d				_						-		
9 ×	leath certifical attending phy I for use as th	Physician/Med	IF FEMALE:	23c. If ves. outcome	of pregnar	acv.		-				-	on De			
Вох	atten for us	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant a	2 Fetal	death 3	Ectopic pr Other (sp					23		ite of delive onth	ery Day	Year
P.O.	that the de led by the a detached i	ysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			,									
σ.	The law requires that the ate has been signed by thoage 2 should be detached.	by Pi	Part II. Other significant conditions of	ontributing to death b	ut not resu	lting in the ur	nderlying c	ause give	en in Part I.		23e. Did to	obacco us	e con	tribute to ti	he cause of	death?
rds	w require been sig should b	ed t									1 🗆 1	/es 2 □	No	3 Prot	oably 4)Unknown
Records,	e law requ has been je 2 shoult	Completed									24a. Was		24b.	Were auto	psy findings	available cause of
		Con										rmed? 2□No		death? 1 Yes	mpletion of No	
Vital	lysician: Th	Be	25. Was case referred to medical examiner?	Hospital:				Othe		of Deati	h Check only o	пө				
of	<u>×</u>	2	1 Yes 2 No 27. Manner of Death	1 L Inpatre		R/Outpatien 28b. Time of			4 🗆 140	-	me 5 Resident			-	y)	
Ou	ding I	흔	1 Natural 5 Pending Accident investigation	28a. Date of Inju (Month, Da	y Year)	Injury	м	8c. Injury Work	k? Yes 2 □		200. 2000.00	ion injury	00001	.00		
Division	Attending r death. ector: After by the fune	Illca	3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At hor	me, farm, str	eet, factory	, office			28f. Location (5	Street and	Numl	ber or Rura	al Route Nur	n <i>ber</i> ,
Ö	tal or s afte al Dir	Certification:	4 Homelde	building, et	.с. (эрөспу,	,					City or Tov	WI, State)				
	To the Hospital or Attending Phymitin 24 hours after death. To the Funeral Director: Alter th completely filled in by the funeral	Medical	29a. Certifying Ph (Check only one) Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	f examinati	viedge, death ion and/or inv	occurred estigation	at the tim , in my op	ne, date an pinion, dea	nd place, ith occurr	and due to the red at the time,	cause(s) a date and p	ind ma	anner as s and due to	tated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	Ĺ			290	. License	number			29d. Date	signe	d (Month,	Day, Year)	
	•		Pupul	_			۲,	53	89			2/	16	0		
	2		1/ 1/	completed cause of c	death (Item	23a) (Type,		37	- 7))+: =	more,	2	0	1/21	210	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	4-						11-17/25	, 1	100	۷.	-10	
	Registr	-	FFR 9 7 3	nns &		be B	make !	þ								

			For State Registrar	State of Ma	aryland /		artment rtificate			and M		giene	006	0	5773
			Decedent's Name (First, Middle,	Last)							2. Date of Dea				3. Time of Death
	Physicia		EVELYN	MINIYAG	2 0						Month 2	Day		106 (03:45PM
-	/Medic		4a. Facility Name (If not institution,		<u> </u>		4h City T	Town or	Location o	of Death	02_	<u>~</u>	County of		07, 171
	Examin	er	MANORLARE W	-	WALES	,									
	r .				e (In yrs. last				nsvi If Under:	LLE 24 Hrs.	8. Date of Birt	h	Balti 9		e (State or Foreign
	Funeral Director		237-20-7329	1 □ M 2 🖾 F	83	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da Feb. 12	Year)	23 8	Country)	e (State or Foreign) Carolina
			Usual Residence of Decedent								100. 1	, , _ , _	-5 5	ouen	Carorina
	ylanc now		10a. State 10b. County		10c. City, To	own or Lo	ocation					-		10d.	Inside City Limits
	Man	to	MD Balti	more	C	aton	sville	2							1 ☐ Yes 2X No
	r 288	Director	10e. Street and Number				10f. Zip (Code				10g. Citiz	zen of Wha	at Country	?
	filed within 72 hours after death with the Maryland Hygiene. sthar than "natural", or Itams 23a or 28a-f show ant, the Medical Evantier must be redified at	Δ	801 Winters	Lane Apt 2	26		2	2122	8			US	SA		
	deati	Funerai	11. Marital Status	12. Was Decedent		13.	Was Decede	ent of His	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	. 7		American	
ပ	after or Ita	Ē	1 Never Married 2 Marrie							i, Pueno	rican, etc.)			White, etc.	
8	ral', c	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:			1□Yes 2	LALNO	Specify:				Specify:	Whi	te
21215-0036	72 ho	Completed	15. Decedent's (Specify only highest	Education	16		dent's Usual kind of work			t of worki	na	16b. Kir	nd of Busin	ness/Indus	itry
2	thin Ban "I	p i	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT use	e retired))		g				
7	ar th	Son	8			Ho	memake	er)wn H	ome	
Maryland	al Hy al Hy a oth vani	Be (17. Father's Name (First, Middle, L.								(First, Middle,				
<u>a</u>	Ment Ment arked	2	Charles H. E	thridge					An	nie	Margare	t Fr	eema	n	
a.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 271s marked other than "natural; or ttams 23a or 28a-f show any injury or other traumatic avant, the Medical Evantmer must be notified at once.		19a. Informant's Name/Relationshi					•			l Route Numbe			-	ode)
Σ.	and 2 valth 1 27 l er tra		Donald D. Clark	e-Former Sp	ouse (6634	Dogwo	od I	Road;	Ba1	timore,	MD	2120	7	
Sre	of He of He roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	3 Demoved from State	20b. Place ceme	of Dispo	sition (Name	e of her place	9)		ate	20c. Lo	cation - Ci	ty or Town	, State
Baltimore,	Page nent int: If		`4 □Donation 5 □Other (Spe		Mt. (Olive	et Cem	neter	rv	2-25	-2006	Ba1t	imor	e. Ma	rvland
=	mit. partn sorta / inju		21. Signature of Funeral Service Li	censee	1	22	2. Name and	Addres	s of Facilit	Ste	rling-A	şhtc	n_Scl	hwab-	Witzke
m	permi Depa Impo any it		1 ema	124			runera 1630 F	Edmor	ome o ndson	I Ca	tonsvil nue: Ca	itons	Inc.	e. MD	21228
			23a. Part1. Enter the disease, of c	omplications that caused	the death. D									Ar	pproximate terval Between
Ш	Physician		shock, or heart failure. List o Immediate Cause (Final	•		,	- Ann I		0						nset and Death
	/Medical		disease or condition resulting in death)		a consequence		-1114	132						_	
	Examiner			Dub to (0) 23	a consequent	ou oi).									
	2	ē	Sequentially list conditions, if any leading to immediate	b. Due to (or as	a consequenc	ce of):									
K	uted Insit	든	cause. Enter Underlying Cause (Disease or injury												
1	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequenc	ce of):									
760,-	Attanding Physician: The law requires that the death certificate be executed redeath. The there this certificate has been signed by the attending physician and sctor; Atter this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	icai												1	
687	ficate phys s the	edic		d											
×	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								1 2	3d. Date o	of delivery	
Вох	atter for t	ciar	in the past 12 months?	1 Live birth 4 Pregnant at			Ectopic pre Other (spe						Month		y Year
o.	the d the ched	ysi	1 □ Yes 2 ☑ 1√0 9 □ Unknown	9□ Unknown				- 77							
ص	res that the de igned by the a be detached f		Part II. Other significant condition	s contributing to death b	out not resulting	g in the u	nderlying ca	ıuse give	ın in Part I.		23e. Did to	obacco u	se contribu	ute to the o	cause of death?
ds	sign sign d be	d by	TYPE II	DIABET	23	n EL	LITU	21			1 🗆 🗅	/es 2[]No 3	Probabl	ly 4 Unknown
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ě	e faw has l	m	MYPER	TENSION							autop		prio	or to compl ath?	letion of cause of
<u> </u>	ding Physician: The law h. After this certificate has b funeral director, page 2 s	S					_				1 ☐ Yes				□ No
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<u></u>	hysl this c	၉	1 Yes 2 No	1 Inpatie			nt 3 DO/				me 5 Resid				
U C	ing F	lon	27. Manner of Death 1 □Natural 5 □ Pending		y Year)	b. Time of Injury		3c. injury Work			28d. Describe f	iow injury	Occurred		
<u>s</u>	Attand ar death actor: / by the f	cat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	ot be		, .	М		/es 2 □ I		OOL Leasting //	244	d & f f	C / C	
Division of Vital	or At fter c Jirac in by	Certification;	4 Homicide determin	28e. Place of Inj building, et	ic. (Specify)	, tarm, str	reet, ractory,	, опісе			28f. Location (S City or Tov			or Hurai H	oute Number,
	To tha Hospital or Attano within 24 hours after deatl To tha Funaral Diractor: completely filled in by the		One Contilion	Dhusiais - T	-4 1 1	4	.			11					
	Hos 24 ho Fund tely f	lica	(Check only 2 Medical E	Physician: To the best xaminer: On the basis o	f examination	and/or in	n occurred a vestigation,	in my op	e, date an inion, dea	th occurr	ed at the time,	date and	and mann place, and	due to the	e cause(s)
	thin 2 thin 2 tha mple	Medical	one) 29b. Signature and title of certifier	and manner st	a180.		290	License	number			29d. Date	e signed //	Month, Day	v. Year)
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	1		30. Name and address of person w						_		_	0.0	~	2.1	
			KALU UMA	2600 LIB	ERTY F	18141	175 AV	VEL-N.	E B	ALT	MURE	IND	21	415	
	Sta		31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	المعر									
	Registr	ar	FEB 2 7 70	106	a floor	Some	alle 1								

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cicion	Decedent's Name	e (First, Middle,	, Last)								Date of D Month	Da	ay Y	rear	3. Time of I
ysician Medical	Sarki	is	Ya	agjia	an						Febru	Lary	12, 2	006	173
aminer	4a. Facility Name (I	1 .	give street	-			4b. City	y, Town, or				40	c. County of	Death	
		ospital	94		Kino		(salti	MOV						
ral	5. Social Security N 023–16–3		6. Sex 1 X M 2		7. Age (In yrs	i. last birthday Yrs.	Months	er 1 Year S Days	Hours	Min.	8. Date of B (Month, D	ay Year		Country	_
or	Usual Residence of						1				11/13/	LYZU		Massa	chuse
	10a. State	10b. County			10c. C	ity, Town or L	ocation							10d	. Inside Cit
ţo	MD	Balt	timore	e		Te	owson	ì							1 🗌 Yes
Be Completed by Funeral Director	10e. Street and Nur	mper					10f. Z	ip Code			-	10g. C	itizen of Wh	at Country	?
a O	1000 E.	Joppa 1	Rd., #	#309				21	L 28 6			U	SA		
ner	11. Marital Status			vas Dece	dent Ever in	U.S. 13.	Was Dec	edent of Hi	ispanic Or	rigin? (Spe	city Yes or N Rican, etc.)	10-		American White, etc	
臣	1 Never Marri		ed t	Yes Yes, Give	2 □ No		1 ☐ Yes		Specify				Specify:	Whi	
d by	3X Widowed		Y	ear or Da	ites:										
Completed	(Spec	15. Decedent's cify only highest				(Giv	e kind of w	vork done o	during mos	st of worki	n <i>g</i>	16b.	Kind of Busi	ness/indus	stry
g	Elementary/Seco	ondary (0-12)	C	college (1-	-4or 5+)	+		use retired Driv	•				Truck		
	17. Father's Name	(First Middle I	acti				LL UCA	DLIV		er's Name	(First, Middle	e Maide			
Be		Yagjia	-							imro		o, marao	. oumano,		
2	19a. Informant's Na			Print)		10h Mail	ling Addres	ss (Street s			I Route Numi	ber City	or Town St	tate Zin Co	nde)
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	Mr. Pete		1411/3C	OH	20b.	Place of Disp	osition (Na	ame of	Ť		ate	_	ocation - C	ity or Town	State
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** February 15, Pearl T. Anderson 2006 8:05 AM M /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5650 Lightspun Lane Howard Columbia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct 3, 192 Birthplece (State or Foreign Country) **Funeral** 76 1929 Director 216-22-4993 Maryland Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Show Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2√ No Howard Columbia Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5650 Lightspun Lane 21045 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: Specify: black Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Part: If Item 27 is marked of George Tucker Norena Morton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bishop Robinson/son 8550 Timberland Circle Pikesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Sign ture of Euneral II. rvice Licensee Ron II d S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street poce rector was Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition and Physician aa ears /Medical resulting in death) Due to (or as a consequence of): 5 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. I detached ☐Yes 2☐No he 9□ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by should be 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 2□ No 1 Yes 2 1 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer. Division 5 Pending investigation 1 Vivatural М 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide Fo the Hospital 1 P Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Morjth, Day, Year) 29b. Signature and title of certifier 29c. License number D51896 21 66 30. Name and address of person who completed cause of death (Item 23a) (Type-Print)

Registrar

DHMH 17 Rev 1/2001

State

3635

31. Date filed (Month, Day, Year)

FEB

2

8 2006

Marke !

🕅 32. Registrar's Signature

21208

MO

			1 - For State Registrar	State of Maryland		artment of F tificate of		d Mental H	lygiene Reg. No.	06	05777
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Dorothy Abe	11				2. Date of Month Febr	Day	24 20	3. Time of Death
	Examin		4a. Facility Name (If not institution, give str Continuum Care		lle	4b. City, Town, o Sykes		Death		County of Dea	ath
	Funeral Director		210 24 3304	7. Age (In yrs. It	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of (Month) Jan	Birth Day, Year) 6 192	9. Bi	irthplace (State or Foreign Country) Id
	death with the Maryland ms 23a or 28e-f show	tor	Usual Residence of Decedent 10a. State 10b. County Md Baltimor	1 *	, Town or Lo ndall	stown					10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	th with the 23a or 28d	Funeral Director	10e. Street and Number 3668 Waterwheel	Square		10f. Zip Code 21133			10g. Citiz	en of What C	Country?
5-0036	urs atter al', or Ite	by	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Amed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	l I	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 No	lispanic Origin an, Mexican, P Specify:	? (Specify Yes or uerto Rican, etc.))	4. Race - Am Black, Wh Specify: Wh	
0-61212	within 72 ho ene. than "natur he Modical	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	irte. L	lent's Usual Occup kind of work done DO NOT use retired eamstre	1)	f working		d of Busines:	•
land	ild be filed lental Hygi ked other iic event, t	o Be C	17. Father's Name (First, Middle, Last) Irving Lubore				Mart	Name (First, Michael) ha Wash	ingto	n Har	mon
Mary	and 2 should batth and Men n 27 ie marke ier treumatic	-	19a. Informant's Name/Relationship (Type James T. Abell (19b. Mailin 3668	g Address <i>(Street</i> Waterw	and Number of	or Rural Route Nu Square,	mber, City or Rand	Town, State, .allst	Zip Code) 21133 cown, 2 1133
altimore,	t te t		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ Rei ↑ 4 □ Donation 5 □ Other (Specify)	moval from State	emetery, cren	sition (Name of natory or other place idge Me		Date -1-06		ation - City o	r Town, State
Bail	permit. Pages Department of Importent: If i any Injury or once.		21. Signature of Funeral Service Licensee	- /		. O. Box		Haight Sykesv			ome & Chape 21784
08/00,	Physician and Medical Examiner but site private its the private its properties.	edical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last d.	Dyspha Due to (or as a consequence of the second of the s	n's o	lisean					Interval Between Onset and Death
O. Box 6	death certif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	c. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 [Ectopic pregnancy Other (specify)	1		23	3d. Date of de Month	elivery Day Year
ds, r	requires that the de een signed by the a nould be detached t	þ	Part II. Other significant conditions contr	ibuting to death but not resu	ilting in the ur	nderlying cause giv	en in Part I.		id tobacco us		to the cause of death?
Vital Records,	The law ate has b page 2 sl	Completed						a	Was an utopsy enformed?	24b. Were a prior to death?	autopsy findings available completion of cause of
	Physician: r this certitics ral director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Dec Ho.	spital:	ER/Outpatien	Oth		Death Check or		F1011 (0)	
lon or	Phy this	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injur Wor			be how injury		ecity)
DIVISION	To the Hospitel or Attanding within 24 hours after death. To the Funerel Director: Attercompletely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Locatio City or	on (Street and Town, State)	Number or F	Rural Route Number,
	ne Hospi n 24 hou ne Funer pletely till	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Exemine	cian: To the best of my known: On the basis of examinate and manner stated.	wiedge, death ion and/or inv	occurred at the tin restigation, in my o	ne, date and p pinion, death o	place, and due to occurred at the tir	the cause(s) a me, date and p	nd manner a place, and du	as stated. ue to the cause(s)
	To the To the comp	W	29b. Signature and title of certifier	11000 1	ND	29c. Licens	0 0 5 4	218	29d. Date 02 -	signed (Mon	-2006
	4		30. Name and address of person who com OR Ruman B	pleted cause of death (Item	23a) (Type, 1	Print) Palcalm	dun	West	minsk	MD	-2006 21157
	Sta Registr	7.1	31. Date filed (Month, Day, Year) FEB 2, 8, 200	32. Aegistrar's Signat	ure Ao	ade	,				

Certificate of Death

2. Date of Death

05778

3. Time of Death

1. Decedent's Name (First, Middle, Last)

Physician /Medical	Saiyed E. Ahmed				February	25, 200	6 1:22 PM
Examiner	4a. Facility Name (If not institution, give street and number,)	4b. City, Town, o	r Location of Death		4c. County of E	Peath
A. A. W. S.	Montgomery General Hospit	:a1	01ne	y		Monte	omery
Funeral		ge (In yrs. iast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
Director	121-30-1033 ¹ ፟፟ M 2□F	76 Yrs.	Worth's Days	Tiours Will.	January 1	, 1930	India
pu a	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	agation				40d Incide City Limits
show show		Silver S					10d. Inside City Limits 1 ☐ Yes 2 X No
18a-f		211/61 2					
Mith the Party Direct	10e. Street and Number	#010	10f. Zip Code	c	10	g. Citizen of Wha	
s 23s	3330 N. Leisure World Blvd		2090				States
uter death with the Ma reference 23a or 28a-f's niner must be notified niner all Director	11. Marital Status 12. Was Decedent Armed Forces 1 □ Never Married 2 Married 1 □ Yes 2 Married	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
urs aff	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	No	1 ☐ Yes 2X No	Specify:		Specify: A	sian Indian
be filed within 72 hours after death with the Maryland dial hygiene. d other than "natural; or items 23a or 28a-f show event, the Medical Enaminar must be notified at Be Completed by Funeral Director	15. Decedent's Education	16a. Dece	dent's Usual Occup	pation	1	6b. Kind of Busin	ess/Industry
ed within 72 ho ygjene. ner than "natur. it, the Medical I.	(Specify only highest grade completed)	(Give	kind of work done DO NOT use retired	during most of work	ing		,
d with giene	Elementary/Secondary (0-12) College (1-4or 5+	Man	aging Edi	tor		U.S.I.A	٨.
be filed tal Hyg d otherward.	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, M	laiden Surname)	
Menta Menta arked artc en	Saiyed Abrar Ahmed-Hashmi			N. Azim			
should hand hand hand hand hand hand hand han	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or Rura	al Route Number,	City or Town, Sta	te, Zip Code)
alth a	Anne R. Ahmed / Wife	3330 N	. Leisure W	orld Blvd.	#918, Silve	er Spring,	Maryland 20906
of He Item	20a. Method of Disposition	20b. Place of Dispo	osition (Name of	Eebru	ary 28,	0c. Location - City	or Town, State
Page nent int: If	1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Mon: Cremat	matory`or other place tgomery orium, In	20	006	Bethesda	, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at once. To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee				aral Homo/i	Ratharda-C	hevy Chase, Inc.
9 1 2 8	► Mamoxilaevs MC	01420 7	557 Wiscons	in Avenue,	Bethesda,	Maryland	20814
*	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
Physician	Immediate Cause (Final	n Cardiac D					Onset and Death
/Medical	resulting in death)	s a consequence of):	each				
Examiner	Corona	ary Artery	Disease				20 Years
je je		s a consequence of):					
executed in and ial-transit	that initiated events	tes					20 Years
e exe		s a consequence of):					
ne death certificate be executed the attending physicien and ithe attending physicien and ithe for use as the buriat-transit ysician/Medical Examir	d. Hypert	ension					20 Years
ing p as as	IF FEMALE:						
ath ce	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3	☐Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
the a	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant a 9 ☐ Unknown 9 ☐ Unknown	at time of death 5[Other (specify)			Wichia.	Say Tour
d by Jetac	Part II. Other significant conditions contributing to death	but not reculting in the	andorhing source an	van in Port I	22a Did tab	acco uco contribu	te to the cause of death?
law requires that the sas been signed by 2 should be detaction pleted by Phr	Tativit Grand Gran	but not resulting in the u	indenying cause giv	entirant.			Probably 4 Unknown
cate has been s page 2 should					10.10.	3 214110 0	
e law has t je 2 s					24a. Was an autopsy	24b. Wer	e autopsy findings available to completion of cause of
Cete Cete					perform 1 Yes 2	led? deat Mo 1 □	
Iclan Sertifi Sector	25. Was case referred to medical examiner?		101		h (Check only one		
hysl this c	1 ☐ Yes 2 🎇 No Hospital: 1 ☐ Inpati			4 Nursing no	me 5 Aesider		Specify)
After uner uner	27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Da	ury 28b. Time o ay Year) Injury	Wor		28d. Describe how	w injury occurred	
tend death tor. the i	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 □ No	00(1 (0)		
tal or Attending P rs after death el Director: After t ed in by the funere Certification;	determined 200. Flace of It	njury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office		City or Town,	eet and Number o , State)	r Rural Route Number,
	29a. Certifier 1 XCertifying Physician: To the best		h		4.4		
he Hosp in 24 hou he Funei pletely fill edical	29a. Certifier (Check only one) 1	of examination and/or in	ivestigation, in my c	me, date and place, pinion, death occuri	and due to the car red at the time, da	use(s) and manne ite and place, and	due to the cause(s)
o the comple	29b. Signature and title of pertifier		29c. Licens	se number	29	d. Date signed (N	fonth, Day, Year)
F 5 F Ö	1 Mmul	Mn		5061			27, 2006
J***	30. Name and address of person who completed cause of	death (Item 22a) (Tues		7 3001			27, 2000
15				l Blvd	Silver Sr	oring. Ma	ryland 20906
State		trar's Signature	TT- HOLL		The Di		

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State Registrar

			For State Registrar	State of M	aryland		artmen					giene	HIII		57	79
	Physicia		1. Decedent's Name (First, Middle, Las	Janet B.	Alful	tis					2. Date of De Month Februa	Day	, 200	ar	Time of 1 : 51	
	/Medic Examin		4a. Facility Name (If not institution, give)		4b. Cily,		Location	of Death		4c.	County of D	eath		
			Suburban Hospita. 5. Social Security Number 6. Social Security Number 8.		ge (In yrs. la:	et hiethdayd	If Under		hesd		9 Date of Ris		Montgo		/Ctata a	- Coming
	Funeral Director			M 2⊠F	74	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Sept. 8	$\frac{17}{3}$, $\frac{Year}{19}$	31	Birthplace <i>Country)</i> MLSSC	uri Juri	roreign
	pu .		Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Lo	oation					-		104	Inside Cit	. Limita
	Maryle 1 sho	ō	Maryland Montgom	erv		orth		sda							1 🗌 Yes	
	th the	Director	10e. Street and Number				10f. Zip					10g. Cit	izen of What	Country?		
	ath wil	raiD	5801 Nicholson La					208					ited S			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other traumatic event, Ite Medical Exercities must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		Was Deced If Yes, spec 1 ☐ Yes		spanic Or n, Mexica Specify		cify Yes or No Rican, etc.))-	14. Race - A Black, W Specify:	hite, etc.	,	
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra			(Give	dent's Usua kind of wo	rk done d	turina mo:	st of workii	ng	16b. K	ind of Busine	ss/Industr	ry	
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d 2	e filed Il Hygi other	Be Co	17. Father's Name (First, Middle, Last)						18. Moth	er's Name	(First, Middle	, Maiden	Sumame)			
ylar	Menta Menta arkad atic sy	To B	Charles Joseph B						An	nanda	Heisse	erer				
Mar	d 2 should the modern of the m		19a. Informant's Name/Relationship (Richard J. Alfult		d		-				<i>I R</i> oute Numb 29, Nor					352
<u>6</u>	s 1 and f Healt ftsm 2 other		20a Method of Disposition		20b. Pla	ce of Dispo	sition (Nar	ne of	1		ate		ocation - City			
OE.	Page nent o ant: If ury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Mont	netery, crei Egomen natori	Lum.	inerpiac Inc.	e) [1	ebru 200	ary 24,	Beth	nesda,	Mary	land	i
Baltimore, Maryland 21215-0036	permit. Departr imports sny inj		21/Signature of Funeral Service Licen	_	M0019	98 RG 75	Name and bert 57 Wis	d Addres A. I	sin A	ve.,	Funeral Betheso	la, N	ne/ ^{Bet} 4D 208	hesda Chase 14 - 35	a-Che In	evy
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause one cause on each I	d the death. ine.	Do not ent	ter the mod	e of dyin	g, such as	s cardiac o	r respiratory a	rrest,		App	proximate erval Betv set and D	e ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (o) as	IVOUT	\W	V	MI	ur	Now	101					
r w	Examiner		Convention for the soundings	DO TO (O) 25	KIN	15 an	15	di	Sla	se						
11:51PM	sit s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du to (or as	a conseque	ence of):					-					
	icate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as	a conseque	ence of):										
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3, 20,	Attanding Physicien: The law requires thet the death certific r death. r death. ector: After this certificate hes been signed by the ettending p by the funeral director, page 2 should be detached for use as:	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal o	death 3	Ectopic pr Other (sp						23d. Date of Month	delivery Day	, Y	'ear
JANET FER	quires thet the de in signed by the e uld be detached f	þ	Part II. Other significant conditions of	ontributing to death I	out not result	ting in the u	nderlying c	ause give	en in Part	1.	1	tobacco (use contribut	e to the ca	1	eath? Inknown
_ eco	law requires es been si 2 should	Completed									24a. Was	an	24b. Were	autopsy to comple	findings a	available
NE R	sicien: The lav certificate hes rector, page 2										perfo 1 ☐ Yes	ormed?	deat	n? Yes 2□		
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- 6	ding Phys I. After this funeral di	n; To	27. Manner of Death	28a. Date of Inj (Month, Da		28b. Time o		8c. Injury Work	4 🗆 14		ne 5 Resi 28d. Describe			pecity)		
Sion	ttendin death. stor: Afr	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		ay rous,		М		Yes 2]No						
LF-4LF15 Division	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification;	4 Homicide determined	building, e	tc. (Specify)						28f. Location (City or To	wn, State	e)			ber,
A	Hosp 24 house Fune etely fi	Medical	29a. Certifier (Check only one) (Check only one)	ysician: To the best niner: On the basis of and manner s	of examination	ledge, deat on and/or in	h occurred vestigation	at the tim , in my or	ne, date a pinion, de	nd place, a ath occurre	and due to the ed at the time,	cause(s date and) and manne d place, and	r as stated due to the	d. cause(s))
	To the within To the comple	Me	29b. Signature and title of certifier		· · · · · · · · · · · · · · · · · · ·		290	. License	e number			29d. Da	te signed (M	onth, Day	, Year)	
			I Wall	Mus				D6	29	49		02	2/21	106)	
	V		30. Name and address of person who	completed cause of	death (Item :			l God	rost	Own I	Road, B	ethe	eda M	aru1	and ?	2081/
	Sta	te	31. Date filed (Month, Day, Year)	1 69	rar's Signatu			. 000	- Set	WII I	Louis D	,	oua, r.	aryı	and 2	.0014
1	Registr	ar	FEB 2 8 2	UU6 1000	150 R	75 A	All Carlot									

ALICE ALEXANDER 06-01138 RKD

Physici	an	For State Registrar 1. Decedent's Name (First, Middle, Las.	1)			of Death	2. Date of Month	Reg. No Death	Ĭ3, 2ÖÖ6	3. Time of Death 3:30P. M
/Medio Examin	al	Alice 4a. Facility Name (If not institution, give JOHNS HOPKINS HOS			4b. City, Tov	ander wn, or Location of 'IMORE			County of Death	3:30F. ···
uneral rector		5. Social Security Number K 6. Se	7. Age (/	n yrs. last birthday 15 Yrs.) If Under 1 Y Months D	Year If Under 2 Pays Hours	Min. 8. Date of Month	Birth Day Year)	60 9. Birth	place (State or Foreign ntry) unk
In pall	tor	Usual Residence of Decedent 10a. State 10b. County MD NA		oc. City, Town or t Baltimo						10d. Inside City Limits XXYes 2 □ No
3a or 28a	I Director	10e. Street and Number 4603 Frankford	Ave		10f. Zip Co	21206		10g. Ci	tizen of What Cou	*
important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, <u>the Medical Examinar must be notified at</u> DDCs.	by Funeral	11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	or in U.S. 13	. Was Decedent If Yes, specify		in? (Specify Yes or Puerto Rican, etc.	No-	14. Race - Ameri Black, White Specify:	
than "natur the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) N/A		(Giv	edent's Usual O e kind of work d DO NOT use n Disab	done during most retired)	of working	16b. K	Cind of Business/Ir	
arked other atic avent, I	To Be Co	17. Father's Name (First, Middle, Last)		Unkno			's Name (First, Mic		, our arrey	Unknown
n 27 ia m nar traum		19a. Informant's Name/Relationship (7 Coranette McCra	w-Care Pr	ovider	4603 E	rankfo	1400	Balt	cimore,	Md 21206
Important: if Ital any injury or oth ODCE.		20a. Method of Disposition M☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Mt.	carmel	l 2/	Date 21/06		ocation - City or T Ltimore	
any ir		21. Sgn ture of Funeral Service Ligen	Whyen	N 2	larch E 1300 Wa	Address of Facility F/H Wes abash A	t ve, Bal	timo	re, Md	21215
detected for use as the buriat-transit	ilcal Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	on Boly, onsequence of):	y hors	I in Asia	ihey			
ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregr □ Other (specif				23d. Date of delive Month	rery Day Year
0 0	ρ	Part II. Other significant conditions co	ontributing to death but r	not resulting in the	underlying caus	se given in Part I.		oid tobacco		the cause of death?
sete nes been si pege 2 should t	Completed						a a	Vas an autopsy enformed?	prior to co	opsy findings available empletion of cause of 2 X No
certificate irector, peç	Be	25. Was case referred to medical examiner? 1 □X7es 2 □ No	Hospital: 1 ☐ Inpatient	2 🕅 ER/Outpatie	2 DOA	Other	of Death <i>Check</i> of Sing Home 5 .	S. S	€ □Other (See	.6.1
completely filled in by the funeral director.	Certification; To	27. Manner of Death 1	28a. Date of Injury (Month, Day Y	ear) 28b. Time Injury	of 28c. M street, factory, of	Injury at Work? 1 Yes 2110	28d. Description 28d. Location 28f. Location	nct	iry occurred choke m nd Number or Rui	ab. has of for
To the Funeral Diractor: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Ph. 2 Medical Exam	ysician: To the best of r iner: On the basis of ex and manner state	amination and/or	ath occurred at tinvestigation, in	the time, date and my opinion, deat	place, and due to h occurred at the ti	the cause(s	s) and manner as	stated.
	0	29b. Signature and title of certifier			290 1	icense number		29d Da	ate signed (Month	

		1	For State Registrer	State of	Marylan		artment of F		nd Menta	Hygier		0	5781
	Dhysiair		1. Decedent's Name (First, Middl		_	-			2. Date Mor	of Death oth D	Day Ye		3. Time of Death
i.	Physicia /Medic	ai -	Anna Sue	Lattie		yerle					7 23 2 4c. County of D		_8:35p ¯
Ĭ	Examin	er	4a. Facility Name (If not institution Fairhaven	n, give street and num	iber)		4b. City, Town, o		r Death				
			5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Sykesv If Under 1 Year		24 Hrs. 8. Date	of Birth	Carro 9.		e (State or Foreign
	Funeral Director		220-46-2125	1 □ M 2 🟋 F	94	Yrs.	Months Days	Hours		nth, Day, Yea		Country) Md	
			Usual Residence of Decedent						1,10,1				Inside City Limits
	arylan show		10a. State 10b. County Md Cari			y,TownorLo kesvi						100.	TY∑Yes 2 No
	8a-f	cto			Бу	VC2 AT	10f. Zip Code			100	Citizen of What	t Country	
	with ti	=	10e. Street and Number 7200 Third A	Vizonijo				784				Country	•
	eath	erai	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13. \	Was Decedent of H		gin? (Specify Ye		JSA 14. Race - A		
	r iten	Fur	1 ☐ Never Married 2 ☐ Mar	Armed For	ces?				, Puerto Rican, e	etc.)		Vhite, etc	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Madical Examiner and be natified at	þ	3 Widowed 4 □ Divorced	Year or Da	er- ites:		1□Yes 2□XNo	Specify:			Specify:W		
ب ص	72 hc	Completed		it's Education st grade completed)		(Give	dent's Usual Occup kind of work done	durina most	of working	16b.	. Kind of Busine	ess/Indus	try
7	vithin nen han	μ	Elementary/Secondary (0-12)	College (1	4or 5+)	_	DO NOT use retire memaker	a)			domes	tic	
5	Hygle Hygle ther t		17. Father's Name (First, Middle,	Last)			=	18. Mothe	r's Name (First,	Middle, Maio	len Sumame)		
and	d be ental ked o	To Be	Charles Latt					Syc	dney B.	Smit	h		
Maryland	shoul nd Mu marl	-	19a. Informant's Name/Relations	ship (Type, Print)	laught	19b. Mailir	ng Address (Street	and Numbe	r or Rural Route	Number, Cit	y or Town, Sta	te, Zip Co	ode)
ž	alth a alth a 27 ls		Carolyn Beyer	le Bauèr		1734	Gillis			ina.	Md 21	797	2
ore,	es 1 a of He of He fitem		20a. Method of Disposition 1 □Burial 2 □ Cremation	3 DRemoval from 5		Place of Dispo	sition (Name of matory or other pla		Date	1 55	Location - City		
<u>Ĕ</u>	Pag ment ant: t ury o		`4 ☐ Donation 5 ☐ Other (5		Lo		e Park		2-28-06		ıltimo		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: if tiem 27 is marked other than "natural", or items 23a or 28a-f show important: if tiem 27 is marked other than "natural", or items 1. until be natified at once, may injury or other traumatic event, the Moderal Examiner is until be natified at once.		21. Signature of Funeral Service	1 1 1 . 1 .	sert	P	O. Box	95 of Facility	Haight Sykesv	Fune	eral H	ome 1784	& Chape
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	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as a consec	quence of):							
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687	cate t physic the b	dicai		d									
.O. Box 6	at the death certifical by the attending phy stached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Feta ant at time of	aldeath 3	□Ectopic pregnanc □ Other (specify) _	у			23d. Date o Month		ay Year
<u>α</u>	that the		Part II. Other significant condit	ions contributing to de	eath but not re	sulting in the u	inderlying cause gi	ven in Part I.	. 23	e. Did tobac	co use contribu	ite to the	cause of death?
rds,	n sign	ed by								1 🗌 Yes	2 No 3] Probab	ly 4 □Unknown
of Vital Record	The law requires that the sate has been signed by the page 2 should be detache.	Completed								a. Was an autopsy performed Yes 2	13 dea	re autops r to comp th? Yes 2	y findings available letion of cause of No
ita	ician: Th certificate rector, paq	Be (25. Was case referred to medic examiner?						of Death (Chec	k only one)			
of V	this aldi	은	1 ☐ Yes 2 No	Hospital: 1 🔲		ER/Outpatie	nt 31 DOA	-	rsing Home 5		e 6 □Other ((Specify)	
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Division	r Attenter deatlinector:	Certification	3 Suicide 6 □ Could	not be 28e. Place	of Injury - At I ng, etc. (Spec	nome, farm, st	reet, factory, office		28f. Lo	cation (Stree y or Town, S	t and Number (tate)	or Rural F	Route Number,
	Hospita 14 hours Funeral tely fille	Medical C	29a. Certifier 1 Certify (Check only one)	ing Physicien: To the I Examiner: On the b and man	best of my kn asis of examin ner stated.	owledge, deal ation and/or in	th occurred at the to	ime, date an opinion, dea	nd place, and due th occurred at th	e to the caus ne time, date	e(s) and mann and place, and	er as stated	ed. ne cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certif	7-0				se number		29d.	Date signed (Month, Da	ny, Year)
	- > F 0) cup	Surp	•		DOOS	9054		1	11941	K	
	ly.		30. Name and address of perso	n who completed caus	se of death (Ite	om 23a) (Type	, Print) 21784						
	St	ate	31. Date filed (Month, Day, Yea		legistrar's Sigr	nature							
Öse	Regist	rar	FEB 2	8 2006	Particage s	Nº A	024/1						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 23, 2006 **Physician** 12 Noon[™] Henry James Brennan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Little Sisters of the Poor Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 7,1905 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 🕱 M 2 🗆 F Yrs. 100 220-44-2510 Pennsylvania Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County Hygiene. other then "neturel", or Iteme 23s or 28s-f ehow rent, the Modical Examiner must be notified at 1 Yes 2 No Baltimore Catonsville Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21228 601 Maiden Choice Lane by Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 WNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Roman Catholic Priest Church 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Eleanor Sophie Withelber Francis Brennan James ဂ္ 19a. Informant's Name/Relationship (Type, Print) FellowPriest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Very Rev. Ronald D. Witherup, S.S. 5408 Roland Avenue Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sulpician Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3/4/06 Catonsville Maryland Christina L. Hilton Name and Address of Facility Baltimore, Maryland 21214 21. Signature of Funeral Service Licensee Mustina Leonard J. Ruck, Inc. 5305 Harford Rd. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final monig1 Physiciali disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine ettending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No the Hospital or Attending Physician: After this certification, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4☑Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No P 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.
To the Funeral Director: A sympletely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) within 2 29b. Signature and title of certifie 121649 30. Name and a wess of person who completed cause of death (Item 23a) (Type, Print)

SAMBANDAM BAKKARAN 3455 WILL WILKENS AVE, BALTIMORE, MD 21229 ASKARAU SAMBANDAM 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar FFP 9 2

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	•	State of Maryland / Dep 1 - State Registrer Ce	artment of Health and M ertificate of Death	lental Hygie Reg.	21116	05784	
		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death	
Physicia /Medic		Mary Donna Barber		February		12:05 P M	
Examin		4a. Facility Name (If not institution, give street and number)	4c. County of Deat				
		3514 Old Level Road	Havre de Grace		Harford		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo		hplace (State or Foreign untry)	
Director		226-28-0009		May 30,	1919 Vir	ginia	
and *	-	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or L	ocation			10d. Inside City Limits	
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the t	rect	Maryland Harford Havre de	2 Grace 10f. Zip Code	10g	. Citizen of What Co	untry?	
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parificiore, invary faith A LA 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiens. Important: It item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational Lumbility at once.	1 3				c. Location - City or		
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Sta	ate.	TATUCCA DUBYS GUS D.) 31. Date filed (Mönth, 'Day, 'Year) 32. Registrar's Signature	There is you				
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	->-0		> KX	J:W->	L00-		-	741	47	6		2.19.			
		+	30. Name and address of person	who completed cause	of death (Item 31	Ra) (Tupo 1	Print)								
_			RAYMOND W. WIL		6365 CI		54	Smite	416	, B.	e.Himore	MD	2120	9	
	Sta		31. Date filed (Month, Day, Year)		gistrar's Signature	θ									
*	Registra	al.	0 0 CAE	NO ASSESSED	A A	oute	9								

	1 - State of Maryland 1 - State Registrar 1. Decedent's Name (First, Middle, Last)	d / Department of Health and Certificate of Death	Reg. No. 06 05786				
Physician /Medical Examiner	RICHARD AUSTIN BROWN 4a. Facility Name (If not institution, give street and number) Baltimore Washington Medical Ce	4b. City, Town, or Location of Dea	Physican Day 23 2506 6:45 A.M. 4c. County of Death				
Funeral Director	5. Social Security Number 6. Sex 1 $\overline{\mathbb{A}}$ M 2 \square F 80 Usual Residence of Decedent		8. Date of Birth 9. Birthplace (State or Foreign				
r 28a-f sho	MD Anne Arunde1 10e. Street and Number	nie 1 Tyes 2 XNo					
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director	2710 Finch Drive 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 2710 Finch Drive 12. Was Decedent Ever in U.3 Armed Forces? 1 □ Yes 2 □ No 194 If Yes, Give Year or Dates: 194	USA Specify Yes or No- to Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify:					
ed within 72 hou ygjene. ner then "neture t, the MedicalE.	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) 5+	White 16b. Kind of Business/Industry Law					
should be filed and Mental Hygi s marked other umatic event,	17. Father's Name (First, Middle, Last) James Dawson Brown	Grace	me (First, Middle, Maiden Sumame) Sowder Austin				
Pages 1 and 2 sh nent of Health and int; if Item 27 is m iry or other traum	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Mrs. Vi B. Brown / wife 2710 Finch Drive, Glen Burnie, Mary 20a. Method of Disposition 1 Rurial 2 Fi Cremation, 3 Removal from State 20b. Place of Disposition (Name of cemetary, crematory or other place)						
permit. Pages 'Department of trimportant; if ite any injury or ot once.	21. Signature of Funeral Service Licensee	sapeake Cremation 2/2 22. Name and Address of Facility 1 Second Ave	6/2006 Stevensville, Marylan Singleton Funeral Home, P.A. SW, Glen Burnie, MD 21061				
Physician /Medical	23a. Part 1. Inter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. tmmediate Cause (Finat disease or condition resulting in death) Due to (or as a consequ	Do not enter the mode of dying, such as cardia	Onnet and Death				
icate be executed by physiclen and burial-transit b	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen						
ath certification or use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	23d. Date of delivery Month Day Year					
w requires that the debeen signed by the asshould be detached for the deta	Part It. Other significant conditions contributing to death but not resu	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
stcian: The law requires of contificate has been selirector, page 2 should be Completed			24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
ng Phy fter this ineral d	25. Was case referred to medical examiner? 1 Yes 2 No 27. Magner of Death Naturat 5 Pending Accident investigation 1 Hospital: 1 Impatient 2 E	ath (Check only offe) Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the tuneral director. Medical Certification: To	3 Suicide 6 Could not be determined 28e. Place of thiury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Num City or Town, State)						
To the Hospital or within 24 hours after To the Funeral Discompletely filled in Medical Cert	29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29a. Certifier: To the best of my know and manner stated.	vledge, death occurred at the time, date and place on and/or investigation, in my opinion, death occurred. 29c. License number	e, and due to the cause(s) and manner as stated. ured at the time, date and place, and due to the cause(s) 29d. Date signed (Month. Day, Year)				
100	1000	D 43977	PI so sol				
State	30. Name indicate ress of person who completed cause of death (Item 31. Date filed (Month, Day, Year) 32. Registrat's Signate	Drive, Wen Borr	mE-Ms. 21061.				

			State of Maryland / Department of Healt			ZUU	6	05787
			1 - State Registrar Certificate of Deal 1. Decedent's Name (First, Middle, Last)		Date of Deat	eg. No.		3. Time of Death
	Physic		Miriam Creager Orem Berberich		Month	Day 7	Year ZDDA	11:30 AM
	/Med Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locat			4c. County		1 1 2 0 1
			Baltimore Washington Mensical Contr. Com	Burn	19	mn	ne	Anmode
	Funeral		Months Days Hou	ure Min	Date of Birth (Month, Day,	Year)	COU	place (State or Foreign
	Director		215-07-5631		4-8- 191	L6	MD	
	yland now		10a. State 10b. County 10c. City, Town or Location			 		10d. Inside City Limits
	a-1 eh	ctor	MD Anne Arundel Hanover					1 ☐ Yes 2€No
	or 28	Oire	10e. Street and Number 10f. Zip Code		1	0g. Citizen of	What Cou	ntry?
	USO ours after death with the Marylan of, or Items 23a or 28a-1 show Examiner must be notitled at	rail	7548 Old Telegraph Road, #217 21076			U.S.A.		
	ter de	rue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ②XNo	ic Origin? (Specify exican, Puerto Ric	y Yes or No- an, etc.)		ck, White,	
900	J.S. aff	by F	3 ⅓ Widowed 4 □ Divorced Year or Dates:	ecity:		Specif	y: wh:	ite
21215-0026	il K I 3-0030 within 72 hours after death with the Maryland ene. than 'naturel', or Items 23e or 28e-1 show the Madical Examiner must be notified at	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during	most of working		16b. Kind of B	usiness/In	dustry
5	within 72 huiliene.	nple	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)					
	V D D	S	12 Administrative As 17. Father's Name (First, Middle, Last) 18. M	SSISTANT Mother's Name <i>(F</i>				ninistration
Ì		Be		Mary Cath				
	Adryjano Z 2 should be filed 5 and Mental Hygi 1s marked other reumatic event, 1	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu					Code)
	IMC alth a 27 is		Mrs. Cathy Irwin / daughter 8930 Rock Creek	Lane, C	olorod	o Spri	ngs,	CO 80926
() () () () () () () () () ()	Defilition of the year of the year. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic angues.		20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		20c. Location	- City or T	own, State
	Pag ment ent: fi		4 Donation 5 Other (Specify) Loudon Park Cemetery	2-27-2	006	Balti	more,	MD
•	Dail. permit. Depart Import any inj		21. Signature of Funeral Service Licensee 22. Name and Address of F					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such				2106	Approximate
			shock, of heart failure. List only one cause on each line	on as cardiac or re	spiratory arre	951,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)					
3	Examiner		Due to (or as a consequence of):				1	
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والم	DC,		resulting in death) Last Due to (or as a consequence of):					
7) 60	cate be executed physician and the burial-transit	dical	d					
3	The COI (US), F.O. BOX Of The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Da	ite of deliv	erv
100	death death d for u	iciar	in the past 12 months? 1				onth	Day Year
4	that the deed by the detached	hys	9 Unknown					
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1.6	he law requir e has been s ige 2 should	Completed			24a. Was a autops perform	y	prior to co	ppsy findings available impletion of cause of
_ ~					1 ☐ Yes 2	2D No	death? 1 Yes	25 (No
7	OI VILLII Physician: T this certificat ral director, pa	Be	examiner?	Place of Death (C			- /0	
	9 Physer this eral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Nursing Home 28d		w injury occur		<u>y)</u>
	LONSION Of a stending Fater death. Director: After din by the funer	Certification;	2 Accident investigation M 1 Yes	2 🗆 No				
	r Atte	1	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (St City or Town		ber or Rur	al Route Number,
	urs aff	Cel						
	To the Hospital or Attending Pl within 24 hours after death. To the Eunerel Director: Affer the completely filled in by the funeral	edical	29a. Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, dat 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	ite and place, and n, death occurred	I due to the ca at the time, da	ause(s) and ma ate and place,	anner as s and due t	stated. o the cause(s)
	To the Mithin To the	Me	29b. Signature and title of certifier 29c. License number	nber	2	9d. Date signe	d (Month,	Day, Year)
	d) MD D4800	06	C	2/2	131	2006
	100		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Dr. 1	مداي	R	V202	mx
8	Q Q	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	0. /	ון ני	0	٧ / ١	1 '5
	Regis		FEB 2 8 2006 Acres 20 April 2006					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** William S. Burner 2006 A M 24 9:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Crofton Convalescent Center Anne Arundel Crofton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/16/1924 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 81 356-30-9152 Director Ohio Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Expension must be notified at MD Anne Arundel Millersville 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8201 Brandon Drive 21108 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Completed by Specify: white 3 Widowed 4 Divorced ear or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Navy US Gov't 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Burner Anna ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Burner / wife f Health item 27 I 8201 Brandon Drive, Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. Feb. 27, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Stevensville, MD Chesapeake Cremation 4 ☐ Donation 5 ☐ Other (Specify) 2006 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Edneral Service Licens e 1 Second Ave SW Glen Burnie MD 21061 M01411 23a. P. n1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician edia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) the Š signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď been sig Completed 1 Yes 2 No 3 Probably 4 € Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an this certificate has al director, page 2 autopsy performed? necuonia 1 Yes 20 To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 25 1 Inpatient 2 ER/Outpatient 3 DOA After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 (Alatural 5 Pending 1 Yes 2 No I Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature as Itle of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and addre of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS MD. 21401 11(31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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			For State Registrar	State of M		nd / Dep	oartme	ent of H					111115	05	789
	Dhusiais		1. Decedent's Name (First, Middle, L	ast)						1	2. Date of D	eath			ime of Death
	Physicia /Medic			Wilbert		Buckin	gham	, Sr.		. 3	Month	ury	26 20		45 AM
	Examin	er	4a. Facility Name (If not institution, g.				4b. C	ity, Town, o	or Location of				c. County of D		
			Baltimore Washing			enter		len	Bur	nie		1	Anne A		
	Funeral Director		5. Social Security Number 6. 216 09 8783	Sex 7. A 1.2XM 2	ige (In yr: 88	s. last birthda Yrs.	Monti	der 1 Year hs Days	If Under 2 Hours	Min.	B. Date of B. (Month, D. Aug.	irth ay, Year	9. I	Birthplace (Country)	State or Foreign nd
			Usual Residence of Decedent		- 00						Aug.	24,	1917 N	laryla	nd
	ylanc		10a. State 10b. County		10c. C	City, Town or	Location							10d. Ins	side City Limits
	e Ma	cto	Maryland Anne A	Arundel		Glen I	Burni	ie						1(]Yes 2∏No
	or 28	Funeral Director	10e. Street and Number				10f.	Zip Code				10g. C	itizen of What	Country?	
	ath w	rai	6638 Whitmore						061				U.S.		
	ltem Item	nue	11. Marital Status	12. Was Deceden Armed Forces	?	U.S. 13	l. Was De If Yes, s	cedent of H specify Cuba	tispanic Orig an, Mexican,	in? (Speci Puerto Ri	fy Yes or N can, etc.)	0-	14. Race - A Black, W		ian,
39	urs af	by	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Dates	: WW	тт	1 🗆 Yes	2 ▼ No	Specify:				Specify: V	hite	
15ert 1215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or Items 23a or 28e-f ehow event, the Middical Examinar must be troubled at	Completed by	15. Decedent's E	ducation		16a, Dec	edent's U	Isual Occup	pation			16b. H	Cind of Busine	ss/Industry	
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Suckingham, Will Baltimore, Maryland 21	s 1 and 2 should f Heelth and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship Ida Matrau / wi										or Town, State		
<u>ධ</u> ම්	of Heelth of Heelth litem 27 r other tra	-	20a. Method of Disposition	16	20b.	Place of Disp	position (#	Vame of	Court	Apt			ocation - City		D 21061
Z OF			1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		Э	cemetery, cri	ematory o	or other place	′ 1						
<u>3</u>	permit. Page Depertment of Importent: if any injury or once.	1	21. Signature of Funeral Service Lige			ulaney			ss of Facility	/1/20			son, M 1 Serv		
200	Den Period		+ Homos (Deane	Me					001					1 21225
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	/Medical Examiner		resulting in death)	Due to (or a	s a conse	quence of):									
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68	death certifica ettending phy of for use as th		IS SERVICE.												
30 X	tendir tendir or use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			□Ectopic	pregnancy	,				23d. Date of c	lelivery	
O.	the el	उ	1 Yes 2 No	4☐Pregnant a 9☐ Unknown	at time of			(specify)					Month	Day	Year
Α.	res that the de signed by the e I be detached f	E.	Part II. Other significant conditions	contributing to death	but not re	sulting in the	underhiin	3 624150 504	on in Cart I		220 Did	tohanna	use contribute	1	
Division of Vital Records, P.O.	uires Isigne Id be	Ω		ooning to docum	DUI HOL TO	suiting in the	undenying	y Cause givi	on in Pait i.				□No 3□		4 Sunknown
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tal	an: Tifficel tor, p		25. Was case referred to medical						26. Place o	of Death //	1 Yes		1 U Y	es 2 No)
<u> </u>	ysici is cer direc	9	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2] ER/Outpatie	ent 3□ [DOA Othe					6 □Other (Sp	agriful	
0	ding Physician: The In. After this certificate he funeral director, page	ü	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Inju		28b. Time o		28c. Injun	v at	1			ry occurred	iouny)	
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	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Example)	nysician: To the best miner: On the basis of and manner si	JI BXAIIIIII	owledge, dea ation and/or in	th occurre nvestigation	ed at the time on, in my op	ne, date and pinion, death	place, and occurred	due to the at the time,	cause(s)) and manner d place, and d	as stated. ue to the ca	use(s)
_	To the Somple	S -	29b. Signarure and title of certifier				2	9c. License	e number			29d. Da	te signed (Mo	nth. Day, Ye	oar)
			buck lease	chun	M.	٥	,	500	5597.3	3					,
	6X1		30. Name and address of person who	completed cause of	death (Ite	m 23a) (Type	, Print)					, C.EII	VILLE VI		
	9		Zeleke Desse	11500 50	therl	and 1	5:11	WOY	Silve	8 5/	oring	M	o Q	904	
	State Registra	-	31. Date filed (Month, Day, Year) FEB 2, 8, 21	Samegist	rar's Sign	ature	aste s								
	riegistia		LED 7 0 7	JUU KALLANG	The Party	18.50	- Gran								

			For State Registrar	State of Ma	•	epartment of H Certificate of L			giene Reg. No.	006	05790
	Physicia	an a	1. Decedent's Name (First, Middle,	Last)				2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic			RUIZ BREYF	OGLE			FEB 2		26	10:40 M
*	Examin	er	4a. Facility Name (If not institution,			4b. City, Town, or		th	ļ	County of Dea	ın
	<u> </u>		NATIONAL NAVAL 5. Social Security Number 6		NTER e (In yrs. last birtho		ESDA If Under 24 Hrs	8. Date of Bir		MONTGOM	IERY thplace (State or Foreign
w	Funeral Director		551-20-7142 Usual Residence of Decedent	1□ M 2 5 √F	88 Yr	Months Davs	Hours Min.		, Year) 1/191	8 AZ	ountry)
	land land		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	Mary -1 sh	ţō	DC		Washing	gton					1 ¥Yes 2 □ No
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What C	ountry?
	th wit	a D	6200 Oregon Aver	iue		20015-			USA		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23s or 28s-1 show other traumatic avent, its Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1		13. Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	spanic Origin? (S n, Mexican, Puer Specify: Spanish		1	4. Race - Am Black, Whi Specify: Can	erican Indian, le, etc. ucasian
ပို	72 ho	ted	15. Decedent's (Specify only highest		16a. D	ecedent's Usual Occupa	ation	orkina		d of Business	/Industry
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2	e filed within al Hygiene. I other than vent, it e Me	Co	12	-4	Cre	edit Manager		/5: 11:	A finite in	6	
Maryland	Mental F Mental F arked ot atic aver	Be	17. Father's Name (First, Middle, La Jose Raphael Rui	,			Maria	me <i>(First, Middl</i> e, Avalar	, waloen .	Sumame)	
Ž	should and Men a marke umatic	<u>۲</u>	19a. Informant's Name/Relationship		19b. N	Mailing Address (Street a	and Number or R	ural Route Numb	er. City or	Town State.	Zip Code)
Ma	and 2 sho saith and n 27 is m		Mrs. Cindy Brend	. ,, ,		8 Grove Str					
Baltimore,	80= 2		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 4 □ Donation 5 □ Other (Spe		cemetery,	Disposition (Name of crematory or other place eake Cremat	1	Feb 24 . 2006		cation - City or	Town, State Maryland
Balti	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Lie	>>	mo1358	22. Name and Address Rapp Funera	al & Crem				20010
0	3.5		23a. Part1. Enter the disease, or co shock, or heart failure. List or			933 Gist Av		rer Sprin		iryrand	Approximate
1	Physician		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)			SCULAR DISE					Interval Between Onset and Death
4	/Medical Examiner			Due to (or as	a consequence of):					
	há	e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					
X	uted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
\ O	icate be executed physician and s the burial transit	Еха	resulting in death) Last	Due to (or as	a consequence of):					
58760,	ysicis	dical		d							
_		9	IF FEMALE:								<u> </u>
P.O. Box	The law requires that the death certific: ale has been signed by the attending pl page 2 should be detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death	3 Ectopic pregnancy 5 Other (specify)	. ,		2	3d. Date of de Month	livery Day Year
	v requires that the de been signed by the should be detached	by Pt	Part II. Other significant condition	s contributing to death bi	ut not resulting in t	he underlying cause give	on in Part I.	23e. Did t	obacco us	se contribute t	o the cause of death?
r S	quire an sig uld b	ed b						10	Yes 2 🛚	¶No 3□P	robably 4 🗍 Unknown
ပ္တ	awre	Completed						24a. Was		24b. Were a	utopsy findings available completion of cause of
ž	The law	E						autoj perfo	rmed?	death?	s 2 No
ita	ding Physician: The In. h. After this certificate ha funeral director, page	Bec	25. Was case reterred to medical examiner?			-	26. Place of De	ath (Check only			
>	hysic his ce I dire	2	1 ☐ Yes 2 No		nt 2 ER/Outp		4 🗆 Nursing r	Home 5 ☐ Resi	dence 6	☐Other (Spe	ecify)
ū	Ing P	on:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injui (Month, Day	ry 28b. Tir y Ye <i>ar)</i> Inji	ury Work		28d. Describe	how injury	occurred	
<u>s</u> io	tendi Jeath tor: A	cat	2 Accident Investiga 3 Suicide 6 Could no	be -			Yes 2 No	2001			
Division of Vital Records,	tal or Attending rs after death. al Diractor: After	Certification:	4 Homicide determina			n, street, factory, office		28f. Location (City or To			ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai	29a. Certifier 1 XCertifying (Check only one) 1 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination and/	death occurred at the tim or investigation, in my of	ne, date and place pinion, death occ	e, and due to the urred at the time.	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the within To the comp	Ž	29b. Signature and title of certifier	11-		29c. License		_		signed (Mon	
)			Author)	41/_	- W	17 01055	5548A (II	N)	02	23 2	.006
	13		30. Name and address of person wi		eath (Item 23a) (T			NAVAL ME MD 20889			CR.
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	fraile					
10	Registr	ar	FEB 2 8	2006	and St.	, CATALON .					

ORIGINAL

		1 - For State Registrar	State of Marylan		artment of rtificate of			giene	6 057	9
Physic /Medi		1. Decedent's Name (First, Middle, La: William A. Bechte	•				2. Date of Dea Month 02	Day	Year 3. Time of 213	
Exami		4a. Facility Name (If not institution, given Shady Grove Hospi	te1		Rockv				tgomery	
Funeral Director		5. Social Security Number 6. S 184–20–7897 1 Usual Residence of Decedent	ex 7. Age (In yrs. 77	last birthday) Yrs.	If Under 1 Yea Months Days	r If Under 24 H s Hours M		y, Year)	9. Birthplace (State of Country) Pennsylva	
Maryland a-f ehow	tor	10a. State 10b. County MD Montgo		ty, Town or Lo	nery Vil	1age			10d. Inside C	ity Limits
with the 3a or 28	Funeral Director	10e. Street and Number One Gentle Court			10f. Zip Code	20886		10g. Citizen of \	What Country?	
ire, Maryland ZIZIO-UUSO s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinant must be notified at	þ	11. Maritaf Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U Armed Forces? 1 (☐Yes 2 ☐ No CG If Yes, Give Year or Dates:	ast uard	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No		(Specify Yes or No- erto Rican, etc.)		ce - American Indian, ck, White, etc. y: White	
within 72 ho ane. than "natur the Mudical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usuaf Occi kind of work don DO NOT use retii	e during most of v red)	vorking	16b. Kind of B	usiness/Industry	
yland 2 ould be fited Mental Hygic arked other atic event, II	To Be Co	17. Father's Name (First, Middle, Last, Stephen Spade	7	00	ooase ou	18. Mother's N	Name (First, Middle, Bechtel	Maiden Suman		
, Mary and 2 shores saith and N 127 is ma er trauma		19a. Informant's Name/Relationship (Therese Bechtel/c	* .				Rural Route Number omery Vil			
DESILITIONE, INITIONE, INITIONE, INITIONE, INITIONED TO Health a Important: If Item 27 is any injury or other trapones.		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	cemetery, cre	osition (Name of matory or other pi ke Crema		-25-2006		- City or Town, State	
Dair permit. Departi Import any inj		21. Signature of Funeral Service Licer	2 mo)		2. Name and Add Rapp Fu 933 Gis	neral &	Cremation ver Sprin	Servic g MD	е	
Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	plications that caused the deal one cause on each line. a	SEA	PSIS NEV NZ	•	liac or respiratory an	rest,	Approximat Interval Bel Onset and	tween
death certificate be executed estending physician and dor use as the burial-transit	Physician/Medical Exar	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. Due to (or as a consect of Due to its con	ancy al death 3[□Ectopic pregnan				ite of delivery	Year
) ਵੇ ਵੇਰੂ	Physic	1 Yes 2 No 9 Unknown	4 Pregnant at time of o		Other (specify)					
BCOFGS, P.O. law requires that the de as been signed by the 2 should be detached	þ	Part II. Other significant conditions of	contributing to death but not res	suiting in the u	inderlying cause (given in Part I.		es 2 No	tribute to the cause of a	
The lay	Completed							rmed?	Were autopsy findings prior to completion of codeath? 1 ☐ Yes 2 ☐ No	available cause of
OT VITALI Physician: Tribis certifica ral director, p	Be	25. Was case referred to medicat examiner?	Hospitaf:	I ED/Outpation	- 207 DOA C		Death (Check only of g Home 5 ☐ Resid		(0	
UNISION OT I or Attending Phy after death. Director: After this	Certification; To	27. Mannager Death 27. Mannager Death 2 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. In W M 1	ury at fork? ☐ Yes 2 ☐ No	28d. Describe i	now injury occur	rred	
= 5 # 5 E		4 Homicide determined	28e. Pface of Injury - At h building, etc. (Special special)	fy)			City or Tov	vn, State)	ber or Rural Route Nun	1001,
= = = =	Medical	(Check only 2 Medical Example) 29b. Signature and title of certifier	niner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my	opinion, death or	ccurred at the time,	date and place.	and due to the cause(5)
To with To Con		• Signature and this of German	lugar	mo	1				22/06	
10		30. Name and address of person who Truong Bao 13219				town MD	20874			
SI Regis	tate	31. Date filed (Month, Day, Year)	32. Fegistrar's Signa	ature	carde					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 1 per doc 9852 2-28-06 vt

late of Maryland? Department of Health and Mental Hygiene State
RegistrarAmend Item #8 Per FH C853 3/VF/VE/Cate of Death
Decedent's Name (First, Middle, Last)
Albert James Booth Sr. Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:55PM 1300 Ft. 20 06 ames /Medical 4c. County of Death fion, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Rehabilitation Extended Care Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 -16-1918 thplace (State or Foreign Months Days Hours Min. Min. 18 18 18 VA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1₽M 2□F -16-144 87 Yrs Director Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Itama 23a or 28a-f show the Medical Examinar must be notified at XXYes 2 No MD Baltimore Director NA 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 21215 U.S.A. 3512 Spaulding Ave death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be tiled within 72 hours atternent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "natural", or Ite ty Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖫 No Specify: Black þ 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Navy 1st grade na Gunner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pattie Edmond Garfield Booth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Ann Casey-Daughter 3512 Spaulding Ave, Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XIXBurial 2 Cremation 3 Removal from State permit. Page Depertment of Importent: If sny injury or once. 4 □ Donation 5 □ Other (Specify) Garrison Forest 3/1/06 Owings Mills, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ementia MKnown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certiticate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending p use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed!

1 Yes 2 2 No certificate 2□ No 1 ☐ Yes or Attending Physician: funeral director Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manufer of Death 28b. Time of 28d. Describe how injury occurred Atter Injury 1 Natural 5 Pending М 1 TYes 2 No death. investigation 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a

To the Funeral C

completely tilled i To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Sigpature and title of certifier 29d. Date signed (Month, Day, Year) 34359 (OHIO) Carl 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Raven Roulevard, Baltimore. Mary land 21218
32. Egistrar's Signature m.D. 3900 31. Date filed (Month, Day, Year) State FEB 2 8 2006 Registrar

			For State Registrar	State of Ma	ıryland	•	rtment of H tificate of L		•	giene Reg. No.	006	05793
	Physici	an	Decedent's Name (First, Middle, Last,				20160		2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	KOSA EE 4a. Facility Name (If not institution, give				4b. City, Town, or	Location of Death	Februa		2000	
	Examin	er	Johns HOPK		tiges	-91	0 11 .	ove cot	7		, o	
	Funeral Director			7. Age	(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birt	h Y. Year 22	9. Birtl	hplace (State or Foreign Carolina
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Maryl -f eho	tor	Maryland Carroll		P	liller	s					1 ☐ Yes 2 🛣 No
	or 28e	Jirec	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Co	untry?
	ath w	ral	4215 Grave Run Ro		: 110	140.1	2110		W N	14	U.S.A.	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 ie marked other then "naturel", or Iteme 23e or 28e-f ehow empt igluty or other treumatic event, I'm Medical Exam nation notified at Ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		l II	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	spanic Origin? (S) n, Mexican, Puerto Specify:	pecay reside No o Rican, etc.)		Black, White	
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, Maryland	and 2 sho alth and 1 a 27 ie ma er treuma		19a. Informant's Name/Relationship (7) Fay Butler - daugh				g Address <i>(Street a</i> Harvey Gt					
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Balt	permit. Departimport eny inj		21. Signature of Funeral Service Licens J. Jank Cll	ee		Ec 32	khardt Fi 96 Charmi	ineral Ch l Dr. Ma	napel P. ancheste	A. r, Md	1. 2110	2
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each lin	the death.		er the mode of dying	1	or respiratory a	rest,		Approximate Interval Between Onset and Death ONE HONTE
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rds, P.	quires that t n signed by uld be deta		Part II. Other significant conditions co	ntributing to death bu	ut not result	ing in the ur	nderlying cause give	en in Part I.	1	obacco use Yes 2 🛭	/	the cause of death?
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/ita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		ath (Check only o	ne)		
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on	Attending r death. ector: After by the fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day	(Year)	Injury	Worl	(? Yes 2 □No		, ,,_,,		
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Attenth completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury - At hom c. (Specify)	ne, farm, str	eet, factory, office		28f. Location (. City or To		Number or Ru	ural Route Number,
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4	o V		29b. Signature and the of certifier A A S S 30. Name and address of person who c A 1 4 5 A S 31. Date filed (Month, Day, Year) FEB 2 8 20	ompleted cause of d	eath (Item 2	23a) (Type,	Print) wolfe	street	Balt	m 21e	· Mar	yland 2128
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 8 20	32 Registra	ar's Signatu	re do	arle					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) 3. Time of Death Month February **Physician** 24,2006 Harry George Coulter, Jr. 4:30 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore County Gilchrist Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec. 23, 5. Social Security Number 6. Sex 1 → M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 76 Yrs. Boston, MA. Director 018-24-3500 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show sumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 228 Deerfox Lane 21093 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 19 Yes 2 □ NKOYEAN If Yes. Give Year or Dates: Conflict 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White δ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore County Parks College (1-4or 5+) Elementary/Secondary (0-12) and Recreation 06 <u>Assistant Director</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental Lolita Blagden Harry George Coulter, Sr. 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn(nee Snouffer)Miller Coulter 228 Deerfox Lane permit. Pages 1 and 2 s Department of Heelth ar Important: If Item 27 te eny injury or other trau sncs. Timonium, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Tremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugeral Service Licenses Peaceful Afternatives Funeral&CremationCtr.,P.A. 2325 York Road Timonium,Maryland 21093 ave Part Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) CreA **Physician** /Medical Due to for as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificete has been signed by the ettending physicien and irector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1 Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; 1 Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel a within 24 hours aff To the Funerel DI 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie no completed cause of death (Hem 23a) (Type, Print) St. Bolto Md 21204 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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DHMH 17 Rev 1/2001

Registrar

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Division of Vital Records, P.O. Box 68760,	To the Hospit within 24 hours To the Funers Completely fille
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		Physic		Decedent's Name (First, Middle, Last)	Walte	er Howa	ırd Coc	k			2 Date of Dea Month Februar	Day	Year 2006	3. Time of Death 12:52 AM
		/Medi Examir		4a. Facility Name (If not institution, give s Stella Maris Hosp					Town, o	r Location of Death		4c. County Balti	of Death	
		Funeral Director		213-18-3300	M 2□F	7. Age (In yrs. 86	last birthday, Yrs.		r 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 2			lace (State or Foreign stry) yland
		vith the Maryland t or 28e-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Ba	ltimor		ty, Town or L	ocation	F	ort Howar	·d		1	0d. Inside City Limits 1 ☐ Yes 2 ऄ No
•		th with the 23a or 28e	Funeral Director	10e. Street and Number 7709 Shadyside Ro	oad			10f. Zi	Code	21052	1	Og. Citizen of V		•
12:52 a.m	920	or Heme	Ď	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	I2. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2 No	J.S. 13.	Was Dece If Yes, spe 1 Yes		ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	es or No- etc.) 14. Race - American Indian Black, White, etc. Specify: Whit		
	Baltimore, Maryland 21215-0036	d within 72 hours giene. Ir then "natural"; Ibe Mudical Exi	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 11 Years	cation completed) College (1	-4or 5+)	(Give	dent's Usu a kind of wo DO NOT u	se retired	ation during most of wor d)	king	16b. Kind of Bu		ustry
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Y 24,	, Mary	permit. Pages 1 and 2 should be filed within Depertment of Heelth and Mental Hygiene. Important: If Item 27 ie marked other then any Injury or other freumatic event, Item 2008.		19a. Informant's Name/Relationship (Type Mrs. Mary Jane C		Wife)	7709	9 Sha	dysi	and Number or Ru de Road				
FEBRUARY	imore	Pages 1 annount of He		20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from	State	Place of Dispo cemetery, cre ak Lawi					20c. Location - Baltimo		wn, State Maryland
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4		Physician		23a. Fart1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on e	aused the dear ach line. CANCE		ter the mod	le of dyin	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
		/Medical Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury		or as a consec								
	8760,	ate be executed hysicien end he burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):							
C00K	P.O. Box 68	ath certifica titending ph or use es t	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live b	come of pregni irth 2 Feta ant at time of co own	al death 3[⊒Ectopic p ⊒ Other (sp				23d. Date More	e of delive	ry Day Year
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	Division of Vital Records,	ng Phys fter this ineral dir	lon: To Be	27. Manner of Death 1 XNatural 5 Pending		npatient 2 [] of Injury h, Day Year)	ER/Outpatien 28b. Time of Injury		8c. Injun	er: 4 🗌 Nursing H	th Check only on ome 5 Reside 28d. Describe ho	ence 6 X Othe		HOSPICE
	Division	ofter death efter death Director: A d in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace buildir	of Injury - At h	ome, farm, st fy)			res 2 LINO	28f. Location (St City or Town	reet and Number, State)	ar or Rura.	l Route Number,
		To the Hospital or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	er: On the ba	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	h occurred evestigation	at the tim	ne, date and place, pinion, death occur	, and due to the carred at the time, d	ause(s) and ma ate and place, a	nner as st and due to	ated. the cause(s)
		To the vithin comp	¥	29b. Signature and title of certifier	7				_	3725	2	9d. Date signed		4
		J		30. Name and address of person who couple. TARIQ MAHMOO	D 230	O DULA	NEY VAI	Print)			1, MD 210			
		Sta Registr	_	31. Date filed (Month, Day, Year) FEB 2 8 2006	32. R	egistrar's Sign	ture	NE S						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 5:07 P M Ellsworth Lee Cunningham Feb. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21 Lake Drive Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☑ M 2 □ F Director Maryland 220-32-2949 70 April 15,1935 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28e-f show other traumatic event, the Modical Exemples must be notified at 1 TXYes 2 □ No Marvland Harford Bel Air Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21 Lake Drive 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: White ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Hardware Sales Sales Representative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellsworth Preston Cunningham Ruth Mary Crouse ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Lake Drive, Bel Air, Maryland Doris M. Cunningham - Wife 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Mt.Christian Chr.Cem. 2/25/2006 Joppa, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Sanda Licensee 22. Name and Address of Facility McComas Funeral Home, P.A \$1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he had failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mos Due to (or as a consequence of): Ollarad While Myhos Si Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of Physician/Medical Examiner 2/ Golden Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2. A No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 3 DOA

Physician /Medical Examiner

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Baltimore, |

Box 68760,

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Division of Vital Records,

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27. Manner of Deat

MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending

28a. Date of Injury (Month, Day Year)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. escribe how injury occurred

Natural 2 Accident investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

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1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dato and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. Ligense number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

within 24 hours e To the Funerei

the

State Registrar

Medical

9. Smolelon Stephen 31. Date filed (Month, Day, Year)

29a. Certifie

(Check only one)

> FFR 2

2021 32. Registrar's Signature

DHMH 17 Rev 1/2001

		í	1 - State of Maryland / Dep	artment of Health and Nertificate of Death		ene 2006	5798
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		George Monroe Cox		Month February	Day Year 7 25, 2006	12:38 P ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	12:30 F
	LAdiliii	CI	618 Fountain Street	Havre de Grace		Harford	
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		8. Date of Birth		ace (State or Foreign
	Funeral Director		212-50-2538 № № 2□F 56 Yrs.	Months Days Hours Min.	(Month, Day,	Year) Coun	try)
			Usual Residence of Decedent		June 23,	1949 Mary	/Land
	land		10a. State 10b. County 10c. City, Town or I	ocation		1	Od. Inside City Limits
	Mary if sh	ō	Maryland Harford Havre	le Grace			1 ☐ Yes 2X No
	the 288	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	to/2
	with a or		618 Fountain Street		10		
	eath	Funeral		21078 Was Decedent of Hispanic Origin? (Sp	north Van ar Na	USA 14. Race - Americ	on ladina
	lten	Ë	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
36	rs af	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 【XNo Specify:		Specify:	
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or liems 23a or 28e-f show other than "natural", or liems 23a or 28e-f show event, the Medical Evantical manual be routiled at	ba		edent's Usual Occupation	4.		nite
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Maryland	th and the street traur			ling Address (Street and Number or Ru Fountain St., Hav			-
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0	ges for the life or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cr	ematory or other place)		Oc. Location - City or To	wn, State
Baltimore,	permit. Pages 'Department of the Important: If ite any injury or ot once.		`4 Donation 5 \$\overline{\text{Other (Specify)}} Entombrent Harford			Aberdeen, Ma	ryland
all all	Deparition Departiment Important Incomposition Department Incomposition		21. Signature of Funeral Service Licensee	2. Name and Address of Facility ICCOMAS FUNETAL HO	me, P.A.		
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П			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
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	/Medical		resulting in death) Due to (or as a consequence of):	MYPERTENSION	1.110010	Seignic	
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P.O.	that the de ed by the detached	Physician/M	9 Unknown				
	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to th	e cause of death?
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1	: The cate had page	ပိ					212 No
Vital	ysiclan: is certitical	Be	25. Was case referred to medical examiner?		th (Check only one)	
of	80 %	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati			nce 6 ☐ Other (Specif))
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Sio	Attending r death. sctor: Atte by the tune	cati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	Route Number,
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	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely tilled in by the to	edical	29a. Certifier (Check only open) 2	th occurred at the time, date and place	, and due to the cau	use(s) and manner as st	ated.
	in 24 in 24 ihe F	edi	one) and manner stated.	Trestigation, in thy opinion, death occu	neo at the time, dat	te and place, and due to	trie cause(s)
	To the within 2. To the complet	Σ	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)
}				1)0062903	3 0	2/27/06	
	17		30. Name and address of person who completed cause of death (Item 23a) (Type	o, Print)	0 :		
	1 "		Anas Atrash, MD 319	5 Union Ave	Defrac	c .MD 21	3FC
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1.0		1	
	Registr	ar	FFR 2 8 2006 America A A	2846			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Callanan Dorothy Antoinette February 26, 2006 9:19 A ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Calvert Manor Nursing Home Rising Sun 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months Days | Hours | Min. 5. Social Security Number **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M X F Yrs. Director 88 215-10-0298 July 7, 1917 | Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or Iteme 23s or 28s-f show other traumatic event, the Medical Exertains must be explitted at 1 Yes 2 No Directo Maryland Cecil Port Deposit 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 22 Fox Fire Drive 21904 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Edward Davis Mary Jackson Barber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Fox Fire Drive, Port Deposit, Maryland 21904 Michael J. Callanan - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ŏ Department of Importent: If any injury or once. Harford Mem. Gardens 3/03/06 Aberdeen, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 50 W. Broadway Street, Bel Air, Maryland 21014 1. Aught 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** myocardial Infarction one day disease or condition resulting in death) /Medical Due to (or as a consequence of): Coronary 5 years arteru Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
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9 Unknown Month Vear Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cerchovascular accident 1 ☐ Yes 2. No 3 ☐ Probably 4 ☐ Unknown Completed heart 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No congestive 24a. Was an 2 No Hyperleasion 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural

Examiner The law requires that the death certificate be executed burial-transit Box 68760. physician for use as the ed by the a P.O. of Vital Records, cate has been sig , page 2 should b funeral director. this Hospitel or Attending after death. filled in by 24 hours a completely within 2 the

Baltimore, Maryland 21215-0036

1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number D00048050 29d. Date signed (Month, Day, Year) 27/06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15 South Parke Street Prashant Shakla mo

Aherdeen ma Zwol

State Registrar

DHMH 17 Rev 1/2001

FEB 2 8 2006



Medical

	·	- FOF	artment of Health and Mental Hygiene rtificate of Death Reg. No. 0 1 6 0 5 8 0 0
Physicia /Medica		1. Decedent's Name (First, Middle, Last) Andreas Carl Chrambach	
Examine	er	4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL	4b. City, Town, or Location of Death BETHESDA 4c. County of Death MONTGOMERY
Funeral Director		5. Social Security Number 565-40-4239 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 7 8 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day Year) 9. Birthplece (State or Fore Country) 9. Birthple
-f show	tor	10a. State 10b. County 10c. City, Town or I	ocation 10d. Inside City Lim thesda 1 □ Yes 2 ☒
oeath with the Maryland ams 23e or 28e-f show if must be notified at	I Direc	10e. Street and Number 9923 Dickens Avenue	10f. Zip Code 10g. Citizen of What Country? 20814 United States
al', or ite	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Narried 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 □ No Specify: 1 □ Yes 2 □ No Specify: Specify: White
then then	Completed	(Specify only highest grade completed) (Giv	dent's Usual Occupetion kind of work done during most of working DO NOT use retired) chemist 16b. Kind of Business/Industry National Institute of Health
H lal H	To Be C	17. Father's Name (First, Middle, Last) Richard Chrambach	18. Mother's Name (First, Middle, Maiden Sumame) Anneliese Friedlaender
t of Health and Men If Item 27 is marks or other traumatic		Birgit C. An der Lan/Wife 9923	ry February 27,
Definit. Tages 1 end 2 Department of Health 5 Importent: if Item 27 is eny injury or other tra 2002.		4 Donation 5 Other (Specify) Cremator	ry 2006 Bethesda, Maryland ium, Inc. 2006 Bethesda, Maryland 2 Name and Address of Facility obert A. Pumphrey Funeral Home/ Chase, Inc 557 Wisconsin Ave., Bethesda, MD 20814-3501
A Sicie	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Dire to (or as a consequence of): C. Due to (or as a consequence of):	
e attending phid for use as th	Physician/Medi		□Ectopic pregnancy 23d. Date of delivery Month Day Year
eugi pe eq	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 X Unkn
the law ete hes b pege 2 st	Completed		24a. Was an autopsy autopsy findings avail prior to completion of cause death? 10 Yes 2 \sqrt{No} 10 Yes 2 \sqrt{No}
or Attending Prysicien Ifer deeth. Director: After this certiful In by the funeral director	Certification: To Be (25. Was case referred to medical examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 5 Death at Homicide 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Place of Injury - At home, farm, so building, etc. (Specify)	of 28c. Injury at Work? 1 Yes 2 No Which in which a caroth t
24 hours a Eunerel I etely filled	edicai C	29a. Certifier 1☐ Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, and due to the cause(s) and manner as stated. Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
1	Mec	29b. Signature and title of certifier Theoden M. Kirky was	29c. License number 29d. Date signed (Month, Day, Year) C.C.M.E. FEBRUARY 24, 2006
Stat Registra		30. Name and address of person who combleted cause of beath (Item 23a) (Type THE NOTE M. King 31. Date filed (Month, Day, Year) FEB 2 8 2006	111 PENN STREET BALTIMORE MARYLAND 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#16b, perFH, C852, 2/28/06 The perFH and Manual Hygione.

			1 - State Registrar		aryland ———		artment of F	Death		Reg. N	2000	05801
	Physici /Media		Decedent's Name (First, Middle,	Willi	am C	1yde	Clement	S	2. Date of Di Month 2	eath Da		3. Time of Death 6:00 a. M
A.	Examir	er	4a. Facility Name (If not institution, Bonvie Inc	give street and number)				r Location of Death .1stown	1	40	Balto	1
	Funeral Director		246-38-6046	. Sex 7. Ag 1 M 2 □ F	ge (In yrs. las 77	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 5-13	irth ay, Year -192	9. Birth Cou	nplace (State or Foreign untry) N • C •
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	own or Lo	cation					10d. Inside City Limits
	deeth with the Maryland rms 23a or 28a-f show r must by matified at	ector		Balto	Pi	kesvi			· · · · · · · · · · · · · · · · · · ·			1 Yes 2 No
	th with t	I Dir	10e. Street and Number	Dog 1			10f. Zip Code 2120	18			itizen of What Cou USA	untry?
920	after or Its	by Funeral Director	722 Greenwood 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?				dispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)		14. Race - Amer Black, White Specify: B1a	, etc.
5-0		eted	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	ient's Usual Occup	oation during most of work d)	king	16b. F	(ind of Business/I	ndustry Unit
Maryland 21215-0036	be filed within 72 ho stat Hygiene. Id other than "natus event, the Medical	Completed	Elementary/Secondary (0-12) 6th grade	College (1-4or	5+) Unk			_{d)} ler Drive		Self	Employed	
nd	and Mental Hygiene. Is marked other than aumatic event, the Mar	Bec	17. Father's Name (First, Middle, La	-				18. Mother's Nam Sarah Di	ne (First, Middle	, Maidei	n Surname)	
ryla	should bind Ment	2	George Clement 19a. Informant's Name/Relationship			10b Mailin	Address /Street	and Number or Rui		or City	as Town Chats 7	i- Codol
	alth an 27 is r		Rosa Clements -			722	Greenwoo	od Road P	ikesvil	.1е ,	Md 21208	p Code) }
Baltimore,	permit. Pages 1 and 2 should be Depermit. Pages 1 and Menta Depertment of Health and Menta Importent: If Item 27 Is marked any Injury or other traumatic as <u>spice</u> .		20a. Method of Disposition 1 ☐ Burial 2 📉 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State			sition (Name of natory or other place ematory	Inc 2/27	Date 7/06		ocation - City or 1	
Balt	Depertit Depertr Imports any Init		21. Signature of Funeral Service Li	censee A	MH		. Name and Addre	ss of Facility M	arch F/ Wabash		Vest nue Balt	to, Md 21215
4	Physician		23a. Part1. Enter the disease, or concern the control of the contr	emplications that caused by one cause on each li	of the death.	Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	4	resulting in death)	Due to (or as	a consequen	ice of):	0.10	nsier	Α σ			
	ę	ē	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as		125	reny o	grten	10118	C9!	se	
Ed.	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с			negl	V93cm	er d	se	ase	
68760,	ificate be executed g physicien and is the burial-transit		Tooling in doding past	Due to (or as		,	mic r	mem	1 9			
	difficate ng physi as the l	Aedical	IS SCHALE.	d				7716771				
O. Box	Attending Physician: The law requires that the death certificate be executed rideath. death. ector: After this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)	,			23d. Date of deliv Month	very Day Year
s, P	es that thighed by be detac	by Pt	Part II. Other significant condition						23e. Did	tobacco	use contribute to	the cause of death?
ord	v requir been si should	eted	H	Zhieme	rs	de	men	ha		Yes 2		bably 4 Unknown
Rec	he law e has l	Completed by		· · · · · · · · · · · · · · · · · · ·						psy ormed?	death?	opsy findings available ompletion of cause of
ital	tician: The certificate harector, page	BeC	25. Was case referred to medical examiner?					26. Place of Deat	1 ☐ Yes	2 No one)	1 □ Yes	20XI No
of V	Physic this ce al dire	2	1 Yes 2 No 27. Manner of Death	Hospital:		/Outpatien		4 Li Nursing no			6 Other (Speci	1) 5515T
on	nding f tth. r: After e funer	ation	1 Natural 5 Pending 2 Accident investiga	28a. Date of Inju (Month, Da	y Year)	b. Time of Injury	28c. Injur Wor M 1 🗆	yat k? Yes 2 □ No	28d. Describe	now inju	ry occurred	,
Division of Vital Records, P.O.		Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of Inj building, et	ury - At home c. (Specify)	, farm, stre	eet, factory, office		28f. Location (City or To		nd Number or Rur e)	al Route Number,
	ns Hospitat or n 24 hours afte hs Funers! Dir bletely filled in	Medical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best aminer: On the basis o and manner st	f examination	dge, death and/or inv	occurred at the ting estigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s date an	and manner as a	stated. to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	>			29c. Licens	90115	>		te signed (Month,	
	13	-	30. Name and address of person wi				Print)					
	Sta	† O .	31. Date filed (Month, Day, Year)	Pelsi, ma	ar's Signature	9		1 Her A	ve S	914	imore m	1021215
jė.	Registr		FEB 2 8	2006	ie Je	A STATE OF THE PARTY OF THE PAR	de					
DH	MH 17 Rev 1/2	001		100		1						

DHMH 17 Rev 1/2001

	1 - For State Registrar	State of Maryland	I / Department of Health and Certificate of Death	Mental Hygier	ZIIII B II B K II
Physician /Medical	VIOLA	MAGLE DAV		FEBRUARY	Day Year 3. Time of Dea
Examiner Funeral Director	5. Social Security Number 220-14-925	6. Sex 1 M 200 F	4b. City, Town, or Location of Deal St birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth	4c. Country of Death B A Transport 9. Birthplace (State or For Country) Country
ified at	Usual Residence of Decedent 10a. State 10b. County		Town or Location HITE HALL		10d. Inside City Li 1 ☐ Yes 25
23s or 28s-f s vat be notified			10f. Zip Code	10g. (Citizen of What Country?
at, or items 23s or 28s-f show Examinat must be notified at I by Funeral Director	3 Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 25 No If Yes, Give Year or Dates:	. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 1 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race · American Indian, Black, White, etc. Specify:
ygiene. Nettral, t, the Medical Ext	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education if grade completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	orking 16b.	Kind of Business/Industry
S S S S S S S S S S S S S S S S S S S	17. Father's Name (First, Middle,	MACLUGGIA		me (First, Middle, Maid	2
Health and tem 27 ie m other traum	19a. Informant's Name/Relations	45005RD 20b. Pla	ice of Disposition (Name of	Date 200	y or Town, State, Zip Code) 3\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
Department of Important: If I any Injury or I any Injury or I and Injury or I and Injury or I and I an	15≦ Burial 2 ☐ Cremation ↓ □ Donation 5 ☐ Other (S 21. 9 making Fundal Servi	ST. (22. Name and Address of Facility	2006 EH	LAIR, P.A. 24
ysician Wedical	23a. Part 1. Enter the disease, or	complications that caused the death. only in cause on each line.	Do not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Betwee Onset and Dea
rial-transit	that initiated events resulting in death) Last	b. Due to (or as a conseque c. Due to (or as a conseque d.	ence of):		
d by the attending physicic letached for use as the but Physicic letached for use as the but have licitar/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	death 3 □Ectopic pregnancy		23d. Date of delivery Month Day Yea
8 g	Part II. Other significant condition	ns contributing to death but not result	ting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of deat
page 2				24a. Was an autopsy performed 1 Yes 2 X	
this certificate al director, pag	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ El	R/Outpatient 3 DOA Other: 4 Nursing H	ath <i>Check only one</i> Home 5 Residence	
leath. tor: After the funer the funer	27. Manner of Death 1 XNatural 5 Pendin 2 Accident investic 3 Suicide 6 Could 4 Homicide determ	g (Month, Day Year) gation not be	28b. Time of Injury at Work? M 1 Yes 2 No	28d. Describe how in 28f. Location (Street City or Town, Sta	and Number or Rural Route Number.
Funer Funer ely fill		g Physician: To the best of my knowl Examiner: On the basis of examinatio and manner stated.	ledge, death occurred at the time, date and place on and/or investigation, in my opinion, death occurred	e, and due to the cause urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
To the complet	29b. Signature and title of certifie)_	29c. License number D43725	29d. [Date signed (Month, Dey, Year)
State Registrar	DR. TARIO MAHM 31. Date filed (Month, Day, Year)	32 Registrar's Signatu	VALLEY RD. TIMONIUM,	MD 21093	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / Departing Sta	ment of Health and Mer ficate of Death	ntai mygien Reg. N	ZHU5 U58U4
	Physici	an	Decedent's Name (First, Middle, Last) John P. Donahue			ay Year
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b	c. City, Town, or Location of Death		y 22 2006 2245 ^M c. County of Death
1			Carroll Hospital Center	Westminster		Carroll
	Funeral Director			Under 1 Year If Under 24 Hrs. 8. onths Days Hours Min.	Date of Birth (Month, Day, Yea arch 16	9. Birthplace (State or Foreign Country) 1935 PA
	/land		10a. State 10b. County 10c. City, Town or Location	on		10d. Inside City Limits
	B Mar	ctor	Md Carroll Sykesvi	lle		1 ☐ Yes 2 No
	uth with the 23a or 28	al Dire	100. Street and Number 1700 Fetlock Court	10f. Zip Code 21784	10g. C	Citizen of What Country?
21215-0036	permit. Pagas 1 and 2 should be filad within 72 hours aftar daath with the Maryland Dapartment of Haatth and Mantal Hygiana. Important: if item 27 is marked other then "naturel", or items 23a or 28s-f show important: if item 27 is marked other then "naturel", or items 23a or 28s-f show alvi jolury or other treumatic event, it is Medical Examples must be coulted at ances.	Completed by Funeral Director	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2X Married 13. Was Decedent Ever in U.S. Armed Forces? 1 Never in U.S. Armed Forces? 14. Was Decedent Ever in U.S. If Ye Yes, Give Year or Dates: 1 9 5 3 - 6 1	Decedent of Hispanic Origin? (Specify s, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
15-0	"natu	letec	15. Decedent's Education 16a. Decedent (Specify only highest grade completed) (Give km	's Usual Occupation d of work done during most of working NOT use retired)	16b.	Kind of Business/Industry
12	withir ana. then	dmc	Elementary/Secondary (0-12) College (1-4or 5+) +6 SYS	tems analyst		computer
	Hygid other	e C	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	irst, Middle, Maide	
/lar	Mantal Mantal arked c	To Be	Lawrence Donahue	Mary Hi	.11	
, Maryland	and 2 sho salth and I n 27 le mu		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	ddress (Street and Number or Rural R Fetlock Ct., Sy		
Baltimore,	Pagas 1 mant of Hi tant: If iter lury or oth			ty Crem. 2-26-	-06 Syl	
Ball	permit. Dapartre Importa eny inje		21. Signature of Funeral Service Licensee Paigr Haight Sterbert P	^{ame and Address of Facility} Haig O. Box 195 Syke	ht Fune	eral Home & Chape
-	Physician /Medical Examiner	her	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A Company Compan	ne mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between
68760, ~	Tha law requiras that tha daath cartificate ba exacutad sta has baan signad by tha attanding physician and paga 2 should ba datachad for usa as tha burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): d.			
P.O. Box 6	ras that tha daath cartifinignate by tha attanding I ba datachad for usa as	Physician/Me		opic pregnancy her (sp <i>ecify</i>)		23d. Date of delivery Month Day Year
	quiras thai n signad t uld ba dat	þ	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.		ouse contribute to the cause of death? 2 □ No 3 □ Probably 4 ⊕ nknown
Il Records,	. Tha law requir tata has baan si paga 2 should	Completed			24a. Was an autopsy performed?	
of Vital	Physician: this cartifical	Be	25. Was case referred to medical examiner?	26. Place of Death (C	theck only one)	
to	Phys rat dir	<u>۲</u>	1 Lites 2 Livro 1 Literpatient 2 Li ER/Outpatient 3		5 Residence	6 □Other (Specify)
Division	To the Hospital or Attending Physician: Tha I within 24 hours after daath. To the Funeral Director: Aftar this cartificata ha complately filled in by tha funaral diractor, paga	Certification;	27. Manner of Death 1	Work? M 1 Yes 2 No		and Number or Rural Route Number.
٥	ospital i hours a uneral C ly fillad li	cal Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death oc (Check only 2 Medical Examiner: On the basis of examination and/or investi	curred at the time, date and place, and	due to the cause(s) and manner as staled.
	o the Hithin 24 o the Formplate	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated. 29b. Signature and title of certifier	gation, in my opinion, death occurred a		nd place, and due to the cause(s) late signed (Month, Day, Year)
	-3-8		I have Mo		F	b 23 2006 MD 21157
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin G N) CHAUCS 291 Story AV M 31. Date filed (Month, Day, Year) 32. Registrar's Signature	i Westmin	sten	MD 21157
1	Sta Registi		31. Date filed (Month, Day, Year) FEB 2 8 2006 32. Registrar's Signature	dis		

AEM 06-01257 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item# 23a, 27, 28a f, perme (353, 3/8/06 TT) Department of Health and Mental Hygiene Michael Dulaney 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Dulaney Michael y 18, 2006 4c. County of Death 2006 /Medical February 8:32 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore County

9. Birthplace (State or Foreign Country) Franklin Square Hospital Rosedale
If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 **№**M 2 □ F Days Months Hours Yrs. Director 220-92-7459 40 Dec. 10,1965 Maryland Usual Residence of Decedent Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2X No Directo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7918 St. Monica Drive 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) e filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ie marked Wayne E. Dulaney Wendy M. Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , 1 and 2 st of Health ar Mrs. Wendy M. Dulaney (Mother) 7418 Hokes Road Glen Rock, Pennsylvania 17327 Baltimore. 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ne eny injury or ot once. cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Mem, Park 2/23/2006 Dorsey, Maryland 21. Signature of Funeral Service Libenses 22. Name and Address of Facility 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Methadone intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any lation to misdless cause. Enter Underlying Cause (Disease or injury Due to (or as a consucuante of) ettending physicien and for use as the burial-transif certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death ed by the e 5 Other (specify) o 9☐ Unknown 9 Unknown s been signed by i Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No 24a. Was an certificate 1 Nes 2 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □X7es 2 □ No After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending Fnd 2/18/06 death. investigation Fnd 8:00P M 1 ☐ Yes 2 🕅 No Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Aural Route Number, City or Town, State) Dukes Motel #104 Pulaski Hwy. Rosedale, MD 4 🗌 Homicide f or A found in motel To the Hospital within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ion ca OCME: February 19, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pollak MD 111 Penn Street Baltimore, Maryland 21201 ONICA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 2 8 2006

State of Maryland / Department of Health and Mental Hygiene 05806 1 - For Stete Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 24, 2006Corinne Allison Dougherty February АМ 10:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brighton Gardens Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Months Hours Min 1 ☐ M 2 🔼 F 95 Yrs Director 217-34-1852 6, July 1910 Washington, D.C Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rei', or items 23s or 28e-f show Examiner must be notified at 1 ☐ Yes 2 No Maryland Montgomery Bethesda Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8215 Lilly Stone Drive United States 20817 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after artment of Health and Mental Hygiene. ortent: If item 27 is marked other then "naturel; or ite injury or other treumatic event, the Medical Examination or other treumatic event, the Medical Examination. 1 □Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: ð Specify: 3 XWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Special Assistant to the Chief Federal Government White House Correspondence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Romie Charles Allison Frances Lucy Norris ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madelyn D. Bates/Daughter 8215 Lilly Stone Drive, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20a. Method of Disposition Date 20c. Location - City or Town, State March 2, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal Irom State permit. Page Department of Importent: If any injury or once. '4 □ Donation 5 🗷 Other (Specify) Entombment Silver Spring, Maryland Mausoleum 2006 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00198 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Artherosclerotic Heart Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 ANo Month Day 4□Pregnant at time of death 5 Other (specify) signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypothyroidism 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2X No 1 Yes 2 No After this certification funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospitei or Attending Injury 1 XNatural 5 Pending death. 1 Tyes 2 TNo investigation 2 Accident after deatl Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dav. Year) mon D33357 February 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lee Jonathan Musher, 5530 Wisconsin Avenue #1045, Chevy Chase, Maryland 20815 M.D. 31. Date liled (Month, Day, Year) 32. Registrar's Signature State FEB 2 8 2006 Registrar

			1 - For State Registrar	State	of Marylai			nt of He te of D				iene	06	058	07
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	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Unde	r 1 Year	ff Under	24 Hrs. 8.	Date of Birth (Month, Day,		9. Birtl	nolace (State	or Foreign
	Director		054-16-4207	1 □ M 2 X F	86	Yrs.	Months	Days	Hours	Min.	(Month, Day,	Year) 9. 19	Co	ew Jer	
100	p _i		Usual Residence of Decedent									,,		J., JC1	309
	how		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d, Inside C	ity Limits
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	and and ie m		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Addres	s (Street an	d Numbe	er or Rural R	oute Number	City or	Town, State, Z	ip Code)	_
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Baltimore,	of He		20a. Method of Disposition		20b.	Place of Dispo	sition (Na	me of		Date			ation - City or		
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	Registr	5 P	L L L U	× ZIIIIN I	WAN AR A	Z 30 AM	NA SECTION AND DESCRIPTION OF THE PERSON NAMED IN								

DHMH 17 Rev 1/2001

State Registrar MICHAEL J.MONSOUR

31. Date filed (Month, Day, Year)

LCDR

MC

32. Registrar's Signature

USNR

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 200 <u>Sylvia</u> D. Davis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death, Examiner ank 9 0-1 0 0 \mathcal{O} 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 ☐ M 2 💢 F Days Min Director 219-38-5559 62 04 10 43 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location other then "natural", or Items 23a or 28a-f ehow rent, the Madical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Middle River MDBaltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 136 Roundup Road 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 27 No 1 Never Married 2 Married 1 Yes No þ Specify: 3 Widowed 4 Divorced Black Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2yrs Metris Companies 12th grade Collection Agent 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Depertment of Health and Mental h Importent: If Item 27 is marked oth any Injury or other traums***-18. Mother's Name (First, Middle, Maiden Surname) John C. Hunt Amanda Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3302 Ferndale Ave, Baltimore, Md 21207 James Savoy-Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crematory Inc. 2/28/05 Baltimore, md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. P.mt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final lease or condition sulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien and s the burlal-trensit or Attending Physicien: The law requires that the death certificate be executed to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Year Dav signed by the a 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not-resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificete hes been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2/ No Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after deeth.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) William a. deme, D0023704 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P9 (.WIN 59.40-1P 000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

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44	Funeral		5. Social Security Number	6. Sex 1 X □14 2 F	7. Age (In yrs. last bin		nder 1 Year		Min.	8. Date of Bir (Month, Da	th	9. Bi	rthplace (State or Foreign
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	death with the Maryland me 23a or 28a-f show	ž	10a. State 10b. County		10c. City, Town	n or Location							10d. Inside City Limits I Yes 2 No
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- - - -	be fled within 72 hours after death with the Marylar da Hygiene. da Hygiene. da thygiene. da thygiene. da ther than "natural", or iteme 53a or 28a-f show event. The Medical Examiner must be notified at event.	eted	15. Decedent	ation	t of works	na	16b. K	b. Kind of Business/Industry					
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Man	2 E 5 2		19a. Informant's Name/Relations	Attack	10 m							or Town, State,	Zip Code)
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Ē	Pages nent of int: if it iry or o		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S)		Metro			١ _	2-20	-06		timor	
Baltimore,	permit. Pages 1 an Department of Heel Important: if Item 2 any injury or other once.		21. Signature of Funeral Service		THECTO							7, P.A	
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Vital Records,	The law cate has b page 2 sl	Completed								autor perfo		death?	utopsy lindings available completion of cause of s 2 \(\sum \) No
<u>I</u>	sician: Certifica	Be	25. Was case relerred to medical examiner?						of Death	(Check only o		1 1016	5 2 110
0	Phys this aldii	٠ <u>.</u>	1 ☐ Yes 2 No 27. Manger of Death	Hospital: 1 🔲 In	patient 2 ER/Ou	tpatient 3	DOA Oth	4 🗀 1401	rsing Hor	ne Resid		6 ☐ Other (Spe	ecify)
0	nding l ath. r: After e funer	ation	Natural 5 Pending	g (Month		njury M	28c. Injun Worl	k? Yes 2 □ h		Describe i	iow iiijui	y occurred	
DIVISION	f or Atten efter deat Director: I in by the	Certification:	3 Suicide 6 Could r 4 Homicide determ	ned 286. Place	of Injury - At home, Iai g, etc. (Specify)	rm, street, fa	ctory, office		2	281. Location (S City or Tox	Street an	nd Number or F	Pural Route Number,
2	Hospital o		29a. Certifier 1/1 Certifyin	- Physician T- the									
	To the Hospital within 24 hours of To the Funeral completely filled	Medical	(Check only 2 Medical I	g Physicien: 10 the ba Examiner: On the ba and mann	pest of my knowledge sis of examination and er stated.	dor investiga	rred at the tin ition, in my o	ne, date and pinion, deat	d place, a th occurre	and due to the ed at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier				29c. Licens	e number			29d. Dat	te signed (Mon	th, Day, Year)
	,		Planu	len 1	vi)		P50	283	0	/	196	Neiry	13,2006
			30. Name and address of person	who completed cause	of death (Item 23a) (Type, Print)	trali	· NA	Ha	Sin A	nn	30115	15,2006 MO 11401
	Sta	te	31. Date liled (Month, Day, Year)	40.0	gistrar's Signature	المارا	Jan	100		7 7 7 1	1-16	4-113	2,70
€ 30 1	Registr	ar	FEB 2 8	2006	2.15 . 16	Some	9						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1- State Certificate of Death	05811				
Hagistrar Continuate of Death Heg. No.	00011				
1. Decedent's Name (First, Middle, Last) Physician Rebecca L. Downs And	3. Time of Death				
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	4c. County of Death Anne Arundel				
Fulleral Occupants 10 Mars 17 Mars Month, Day, Year) Co	hplace (State or Foreign buntry) ryland				
Usual Residence of Decedent	10d. Inside City Limits				
Maryland Anne Arundel Severn	1 ☐ Yes 2X No				
Maryland Anne Arundel Severn 10g. Citizen of What Color 10g. Citizen	puntry?				
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 14. Race - Armed Forces? 15. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White Hispanic Origin)					
열 교육 [출] 3 UWidowed 4 UDworced Year or Dates:					
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business (Double kind of working life. DO NOT use retired) 16c. Kind of Business (Double kind of working life. DO NOT use retired) 16b. Kind of Business (Double kind of working life. DO NOT use retired) 16c. Kind of Business (Double kind of working life. DO NOT use retired) 16c. Kind of Business (Double kind of working life. DO NOT use retired)	Industry				
Elementary/Secondary (0·12) College (1·4or 5+) 6th O Domestic Private I	Family				
17. Father's Name (First, Middle, Last) Henry Downs 18. Mother's Name (First, Middle, Maiden Sumame) Mary Levy Brown					
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 g E E	Zip Code)				
Arlene Dance(Daughter) 8203 Clearwater Ct. Severn, Md. 21	1144				
20a. Method of Disposition 20b. Place of Disposition (Name of High Place) 20c. Location · City or High Place 20c.					
21. Signature of Funeral Service Licensee 22. Name and Address of Eacility Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 214					
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death				
Immediate Cause (Final disease or condition resulting in death) The dical timediate Cause (Final disease or condition resulting in death) The dical timediate Cause (Final disease or condition resulting in death) The dical timediate Cause (Final disease or condition resulting in death) The dical timediate Cause (Final disease or condition resulting in death)	Cristi and Obati				
Examiner Sequentially list conditions					
Sequentially list conditions if any, leading to immediate cause. Line Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):					
The soluting in death) Last Due to (or as a consequence of):					
d d d d d d d d d d d d d d d d d d d					
The part of the	23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Pr 24a. Was an 24b. Were at	o the cause of death?				
The state of the s	utopsy findings available completion of cause of				
25. Was case referred medical examiner?					
Described to the special series of the speci	cify)				
Sign of the second of the seco					
27. Mann of Death 1 Valural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 5 building, etc. (Specify) 28a. Date of Injury 28b. Time of Injury M 28c. Injury at Work? 1 Ves 2 No 28d. Describe how injury occurred	ural Route Number,				
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 29d. Date signed /Mont	s stated. to the cause(s)				
29b. Signature and title of certifier Acoust C. Wills 10 11, D. 29c. License number Elbruary	n, Day, Year) 16, 2006				
Heavy C. Wills # M.D. D41365 February 30. Name and address of person who completed cause of death (Kem 23a) (Type, Print) George E. Wicks # M.D. 301 Hospital Drive, Glen Burnie, M.D.	21061				
State Registrar State 31. Date filed (Month, Day, Year) FEB 2 8 2006 State A 2006					

DHMH 17 Rev 1/2001

Downs, Rebecca

ORIGINAL

			1 - For State Registrar		State of M	aryland			nt of He te of E		d Men		iene	006	058	12
1	Physic	ian		e (First, Middle, Las	st)							Date of Dea Month	Day	Year	3. Time of	
\	/Medi	cal	Joseph		street and number)		4b. City	Town or	Location of E		bruary		, 2006 County of Dear	9:10	PM M
	Examir	ier	, ,		Medical		r	,		verly				,	George's	;
	, Funeral Director		5. Social Security N	lumberunk 6. Se	ex 7. Ag ▼ M 2□ F	ge (In yrs. Ia 93	st birthday) Yrs.	If Unde Months	Days	If Under 24 Hours	Hrs. 8. E	Date of Birth Month, Day	Year) 1912	9. Bird Co	thplace (State o	r Foreign unk
	and		Usual Residence of 10a. State	f Decedent 10b. County		10c. City,	Town or Lo	cation							10d. Inside Cit	ty Limits
	Maryl	to	MD	Prince G	eorge's	Riv	erdal	e							1 🗆 Yes	
	or 28s	Director	10e. Street and Nu					10f. Zi	p Code			1		zen of What Co	ountry?	
	ath w	ral		st Place unk	10 Was Davidson	F	140.1			20737	0./0			JSA		
320	n 72 hours after death with the Maryland "neturel", or Iteme 23a or 28a-f show tedical Exeminat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2□ Marned	12. Was Decedent Armed Forces' 1 Yes 2 If If Yes, Give Year or Dates:	? u	ınk '	was Dece fYes, spe I ☐ Yes	cify Cuban	spanic Origin n, Mexican, P Specify:	(Specify Juerto Rica	Yes or No- n, etc.)		14. Race - Ame Black, Whit Specify: W		
215-003b	72 hou	eted	(Spec	15. Decedent's Ed	lucation de completed)		16a. Deced	lent's Usi	ual Occupat	tion uring most of	working	unk	16b. Kir	nd of Business	/Industry	unk
7	c . at	Completed	Elementary/Seco	ondary (0-12)	College (1-4or	5+)	life. L	DO NOT	ise retired)	aring most or	Working					
מע	be filed withing tall Hygiene. Ind other then event, the M	CO	unk 17. Father's Name	(First, Middle, Last)	ınk			1	unk	18. Mother's	Name (Fir	st, Middle, i	Maiden .	Sumame)		unk
yland	Aental I rked or tic eve	To Be														GIII
Mary	s 1 and 2 should be f Heelth and Mental Item 27 is marked of other treumatic ev	,-		ame/Relationship (7										Town, State, 2	_	
a)	es 1 and of Heelth if Item 27 or other tr		Prince G		edical Ce					Drive	Date			D 2078 cation - City or		
Baltimore,	trages traint o rient: If ijury or		1 ☐ Burial 2 4 ☐ Donation	☐ Cremation 3 ☐ 5 ☑ Other (Specify	Removal from State		nce of Dispos metery, crem									
g	Depermit Deper Impor any in		10	neral Service licent	11 DU	ector	В	alti	more.	MD 2	21201			1timore	Street	
			snock or nea	int failure. List only o	olications that cause one cause on each l	d the death. ine.							est,		Approximate Interval Bety Onset and E	ween
). 1	Physician /Medical		Immediate Cause disease or condition resulting in death)		a. FATA	L C		AC	At	CRHY1	THM!	A			Oliset and L	704111
	Examiner				Due to (or as	a conseque	ence of):									
X.		ner	Sequentially list confiance, leading to include cause. Enter Under	nditions, nmediate erlying	Due to (or as	a conseque	ence of):									
	ecuter and -transi	Examiner	Cause (Disease or that initiated events resulting in death) I	injury	C											
8/00,	icate be executed physicien and s the burial-transit	al E			Due to (or as	a conseque	ence or):									į
	ificate g phys	edlcal		•	d											
XOD	death certif e attending id for use a	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy										2	23d. Date of delivery		
9	w requires that the death certific been signed by the attending p should be detached for use as	Physiclan/Me	in the past 12 months? 1											Month	Day Y	'ear
ŗ	that if				ontributing to death b	ut not result	ting in the un	derlying	cause giver	n in Part I.		23e. Did tot	oacco us	se contribute to	the cause of d	eath?
coras	quires an sigr uld be	ed by										1 □ Y	es 2	□No 3□Pr	obably 4 XU	Inknown
ဝ	law requires that as been signed b 2 should be deta	Completed										24a. Was a autops		24b. Were au	itopsy findings a	available
=	: The cate h	Con										perforr		death?	2□ No	1036 01
NE N	dertific rector,	Be	25. Was case reference examiner?		Hospital:				Other	26. Place of						
ō	Phys er this eral di	n: To	1 Yes 2 2	140	28a. Date of Inju	iry 2	R/Outpatient 28b. Time of		28c. Injury a	4 U Nursin		5 Reside		Other (Spec	cify)	
Sion	ath. r: Aft	atlo	1 Natural 2 Accident	5 Pending investigation		y rear)	Injury	м		es 2□No						
	tel or Attu is efter de al Directo ed in by ti	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In	ury - At hom c. (Specify)	ne, farm, stre	eet, factor	factory, office 28f. Location (St City or Town					Number or Au	ıral Route Numi	ber,
	To the Hospitel or Attending Physicien: The law within 24 bours either death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2 a	edical	29a. Certifier (Check only one)	Certifying Phy 2 Medical Exam	vsician: To the best iner: On the basis o and manner st	f examination	ledge, death on and/or inv	occurred	at the time	e, date and pi	lace, and o	due to the ca	ause(s) a ate and	and manner as place, and due	stated. to the cause(s)	1
	To t withi To ti	Σ	29b. Signature and	title of certifier	/			29	c. License	number	1			signed (Monti		
•			• (LA	The state of the s			\	119	845]		2	-02/-	06	
			30. Name and address	ess of person who c	completed cause of c	300/	23a) (Type, F	PITA	1]	XNE	C	HEVE	RLY	MD	2018	5
	Sta Registr	- 35	31. Date filed (Mon	th, Day, Year)	32. Registr	ar's Signatu	23a) (Type, F	(i)								

			1 - For Amend Item 26 per verb., C8526	nent of Health and M 22/27/96 The	lental Hygi	ene 2.006	05813							
		BC ²	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer	3. Time of Death							
п	Physicia /Medic	al .	Lillian Ellison		February		12:24 P M							
	Examin	er	,	City, Town, or Location of Death		4c. County of Dear	auı							
			Sinai Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Baltimore Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign							
	Funeral Director			nths Days Hours Min.	Oct 14,1	1926 Mar	lboro Co,SC							
			Usual Residence of Decedent				I							
	irylan show	_	10a. State 10b. County 10c. City, Town or Location	n			10d. Inside City Limits 1 ☐ Yes 2 📉 No							
	Ba-fs	octo	MD Baltimore Baltimore		10	og. Citizen of What Co								
	with th	直		of. Zip Code 21215		•	•							
	eath vs 23	Funeral Director	4601 Pallmall Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was			Inited Sta								
	fter d	F	1 Never Married 2 Married 1 Tes 2 TNo	Decedent of Hispanic Origin? (Spe., specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit								
ဝွ	ours a	ρ	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	res 2. IX No Specify:		Specify:	Black							
21215-0036	72 hc	Completed by	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind	s Usual Occupation of work done during most of work IOT use retired)	ing 1	16b. Kind of Business	/Industry							
2	vithin ne. hen.	Id m	Elementary/Secondary (0-12) College (1-4or 5+)	nine Operator		T								
7	iled v Hygie ther t		12 Mach	18. Mother's Name	(First, Middle, M	Textile Maiden Surmame)								
and	d be f antal } (ed of	o Be	Harrison Cole	Lillie	Lucas									
Maryland	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other then "neturel", or items 23a or 28a-f show unastic event, if w Modical Exertified in that the netitied at	ြ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ac	Idress (Street and Number or Rura	al Route Number,	City or Town, State,	Zip Code)							
	nd 2 aith a 27 is			Celandine Court,	Charlott	e, NC 282	13							
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or ttems 23a or 28a-1 show any Injury or other treumatic event, II we Modical Eracinet must be notified at once.		20a. Method of Disposition 1	y or other place)	Date 2	20c. Location - City or	Town, State							
<u>E</u>	Page nent ent: M ury o					lallace, So	3							
alt	permit. Departr Importe any Inj		1/ // //	me and Address of Facility Gr										
_	20 E # 9		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the	Highway #1 Sou			20 Approximate							
The state of	Pnysician /Medical Examiner	0	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Seguentially list conditions,											
8760,	tate be executed only sician and the burial-transit	Ilcal Examiner	d											
.O. Box 6	death certific le attending p ed for use as	Physician/Med		opic pregnancy er (specify)		23d. Date of de Month	livery Day Year							
rds, P	quires that the de n signed by the a uld be detached t	ρ	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tob	es 2 ☑ No 3 ☐ P	o the cause of death? robably 4 DUnknown							
Division of Vital Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed			24a. Was ar autops perform 1 🗆 Yes 3	y prior to death?	utopsy findings available completion of cause of s 2 No							
Vita	ding Physicien: Th. A. After this certifical funeral director, p	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Deat										
of	Phys this ral dir	2	1 ☐ Yes 2 ☑ No ☐ Inpatient 2 ☑ ER/Outpatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at Work?		ence 6 Other (Special of the Communication of the C	ecity)							
O	ding h. After fune	tlon	Natural 5 Pending (Month, Day Year) Injury	Work? И 1 ☐ Yes 2 ☐ No										
Divisi	of or Attending after death. I Director: After din by the fune	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (St. City or Town	reet and Number or R , State)	lural Route Number,							
	Hospite 4 hours Funerel tely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occ 2 Madical Examinar: On the basis of examination and/or investigated.											
	within 2 To the comple	Me	29b. Signature and title of century	29c. License number	25	9d. Date signed (Mon	th, Day, Year)							
			1 must	1)57313		2/22	106.							
	(12)		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	"INDEN AVE	BA	TimeRE	21201							
;	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 8 2006 32. Registrar's Signature											

State of Maryland / Department of Health and Mental Hygiene 📋 🖰 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 7:05 February విం06 19 CURLEY EUGENE EDMONDS /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/ABALTIMORE UNION MEMORIAL HOSPITAL Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6-7-1916 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 ☐ F 89 Yrs. 057-16-9077 WEST VIRGINIA Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Show Pages 1 end 2 should be filed within 72 hours after death with the Marylan nent of Health and Mantal Hygiene.

and of Health and Mantal Hygiene.

and it if item 27 is marked other then 'naturel', or flems 23s or 28s-1 show ury or other traumatic event, the Madicial Examples must be ricillified at 1 X Yes 2 ☐ No BALTIMORE MD. N/AFuneral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21213 3729 LYNDALE AVE. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 2 3 T√Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) COLE MINE -10--0-MINER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LUCY EDMONDS GEORGE W. EDMONDS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CONTINIA SCRUGGS (GRANDDAUGHTER) 3729 LYNDALE AVE. BALTIMORE, MARYLAND 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (☐Removal from State 3-3-2006 BALTIMORE, MARYLAND 5 Other (Specify) MT. ZION CEMETERY JONATHAN D. HIBNER Name and Address of Facility REDD FUNERAL SERVICE 21. Signature of Funeral S 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, br deart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Edema Secondary To CHF Approximate Intervat Between Onset and Death 2 days PULMONARY EDEMA SECONDARY TO CHE Physician /Medical Due to (or as a consequence of): 24rs Examiner ISCHEMIC CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires thet the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical ettending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig . page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۵ After this 27. Manner of Death 1 ☑ Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Hairlupe M.D AT 24389 46 February 19, 2006 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , M. D. UNION MEMORIAL HOSPITAL , MD HINA GHAFOOR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 8 2006

Registrar

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day February 25 **Physician** 2006 Foland 11:36 PM Edward Roger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 24, 1935 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F 70 Yrs 214-32-3974 Director Mary land Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits rthen "naturel", or items 23s or 28s-f ehow the Medical Examiner must be notified at 1 Yes 2 □ No Maryland Frederick New Market Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10817 Old National Pike 21774 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No 1958— If Yes, Give Year or Dates: 1961 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Plumber County Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any liqury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Roger H. Foland Catherine V. Yinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Cole / Daughter 10817 Old National Pike, New Market, MD 21774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March 2. 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 □Donation 5 □Other (Specify) 2006 Frederick, Maryland Resthaven Mem. Gardens 21. Signature of Puneral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Part1. Enter the diseas shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ailure **Physician** ON gestive CART 10 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kenal Failure 1 Yes 2 No 3 Probably 4 Unknown Mellirus 24b. Were autopsy findings available prior to completion of cause of death? labetes page 2 autopsy performed certificate 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1-Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hin 24 hours a Medical 29a. Certifie Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO035152 2.26.06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MD 21702 180 Thos MO JOHNSON Daire 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 8 2006

DHMH 17 Rev 1/2001

ORIGINAL

06-1317 B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNKNOWN State of Maryland / Department of Health and Mental Hygiene nthony F. Fertitta 1-Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Anthony Frank Fertitta 2, 2006 0305 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL MILLERSVILLE 8300 blk. OLD MILL ROAD | If Under 1 Year | II Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Oct 18, 1955 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 213-64-7000 1**X** M 2 ☐ F Yrs. 50 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f ehow event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò United States 21227 4424 Annapolis Road or Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Cargo Driver f Health and Mental Hyg Item 27 le marked other 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Emma Elizabeth Crauf Frank Paul Fertitta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1208 Glyndon Avenue, Baltimore, Maryland 21223 Rose A. Acton / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of H Important: If Ite eny Injury or of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 3/1/06 Elkridge, Maryland 21. Signature Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Thanp force in /Medical Examiner Sequentially list conditions, if any, isaging to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a gunsecuanda off Examiner burial-transit Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) noting physicien. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. deteched 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 90 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 XYes 2 No 24a. Was an certificate 12 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) AT SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 X Yes 2 □ No ို ral Director: After this rain by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural Fou Subject Stabled

Location (Street and Number or Aural Route Number, City or Town, State) 1 Yes 2 No 3:05AM 2006 2 Accident 72 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide 3 Suicide 6 ☐ Could not be filled in by determined 8300 block old Mill Rd, Millers ville To the Hospital within 24 hours ele 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number FEB. 22, 2006 O.C.M.E

State

DHMH 17 Rev 1/2001

Tashazareen 31. Date filed (Month, Day, Year)

Courses

30. Name and address of perion who complete cause of death (Item 23a) (Type, Print)

111 PENN STREET, BALTIMORE, MARYLAND 21201

. P

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death edent'ş Name (First, Middle, Last) Physician 5:00 PM /Medical 4c. County of Death Town, or Location of Death Facility Name (If not institution, give street and number) 4b. City. Examiner If Under 1 Year TIMORE If Under 24 Hrs. 9. Birthplace (State or Foreign, Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, **Funeral** -646 Months Days Hours 10 M 2 F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28e-f ehow or other traumatic event, the Mudical Exercities must be notified at 1 Yes 2 No Director 10e. Street and Number Of. Zip Code 10g. Citizen of What Country? 1612 "natural", or Iteme 23a 01 filed within 72 hours after death Funeral Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. QO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event. Elementary/Secondary (0-12) College (1,4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21664 19a. Informant's Name/Relationship (Type, Print) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p. ce) Date 20a. Method of Disposition 23 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Si mature si Fun ira Servici License e 22. Name and Address of Facility Evans Funeral Chapel of 8800 Hartord 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RENAL CARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonecollance of): Examiner burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 Øbinknown CARCINOMA 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 208 No 1 Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 21 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Kombule MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7602 BBRAIR Rd SACTUMA NIM Kuntlers 14 31. Date filed (Month, Day, Year) FEB 2 8 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Geneva Faist February 23, 2006 5:04 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Ctr. Baltimore City N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 M 20 F Director Oct. 30,1925 220-24-4995 Virginia Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10c, City, Town or Location 10b. County 27 is marked other than "naturel", or items 23e or 28e-f ehow traumatic event, the Medical Examiner must be notified at 1 Tyes 2x No Director Dundalk Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 4 Midship Road filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 213 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Administrator Commercial Credit Year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Peges 1 and 2 should be fil tment of Health and Mental H tent: if item 27 is marked oth lury or other traumatic ever Be William C. Morris Elizabeth Collier ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Charles M. Faist (Husband) 4 Midship Road Dundalk, Maryland important: if item, eny injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 2/27/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Box 68760 BETES Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. been signed by the s should be deteched 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hes e 2 this certificete 1□ Yes 2♥No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner' Hospital: 1 ☐ Inpatient 2 ☐ EN/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours efter To the Funerei Dire 29a. Certifier Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) Master 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Warren Forwood Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06 - 1305Unpend item# 23a State of Maryland Popular of Health and Mental Hygiene AKG 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Day 21, 2006 **Physician** Warren G. Forwood 10:18 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a Baltimore Good Samaritan Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** DEDKM 2□ F 81 219-18-5646 Director March 12, 1924 Maryland Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at XX Yes 2 No N/A Director Baltimore Maryland the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21239 1728 Sherwood Avenue Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status be tited within 72 hours after de stal Hygiene. Ida Hygiene. Id other than "natural", or Items Black, White, etc. 1XXYes 2 □ No 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ If Yes, Give Year or Dates: WWII 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Politician City of Baltimore, MD 12 +18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Elsworth Lee Forwood Leona Helmig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Important: If Item 27 is m any Injury or other traum once. 1728 Sherwood Avenue Baltimore, MD 21239 Carolyn Forwood Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State xXBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial 2/27/2006 Cockeysville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burnee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, MD 21211 21. Signature of Funeral Service Vicenses Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a Complications of hip fracture **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner thet the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a deteched f 9 Unknown 9 Unknown s been signed by t should be detech Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Diabetes mellitus; atherosclerotic disease Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

↓☑ Yes 2 ☐ No page certificate 1 Yes 2 □ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ⊠npatient 2 ☐ ER/Outpatient 3 ☐ DOA 1√2Yes 2 No this is After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending within 24 hours etter death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 No investigation 2/15/2006 2 XAccident subject fell unk 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1601 E. Belvedere Ave. 4 Homicide ō Baltimore, MD residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. February 22, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland LGroenber

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

DHMH 17 Rev 1/2001

FEBRUARY

FAUTH

SHIRLEY

			For State Registrar	State of M	aryland	•	artment o				giene Reg. No. () ()6	0582	et established		
	Physici		Decedent's Name (First, Middle, L	2. Date of Dea Month Februa	Day	2006	3. Time of Death 2:25 A									
	/Medic Examin		4a. Facility Name (If not institution, g	therine		Gri	4b. City, Tow	n, or Locati	ion of Death	rebraa		c. County of Death				
			Rose Manor Assi	sted Livir	ng		E1:	licot	t City		Но	Howard				
	Funeral		Social Security Number 6.		ge (In yrs. las	t birthday)	If Under 1 Yo Months Da		der 24 Hrs.	8. Date of Birt (Month, Da	h v. Ye <i>ar</i>)	9. Birthr	place (State or Fore	ign		
В	Director		213-48-6573 92 Frs. JAN								1914		cyland			
	pue *		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										10d. Inside City Limits			
	Maryl f eho	5	Maryland Howa	rd			T2114 -	0					1 🗌 Yes 2 💢			
	the 28a-	Director	10e. Street and Number	.Lu			Ellico		ıty		10g. Citizen of	What Cou	ntry?			
	3a or		8825 Manahan D	rive				043			•	USA	,			
	72 hours after death with the Marylend netural", or Items 23a or 28a-f ehow alcel Examinar must be notified at	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S.	13.			Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Ra	ce - Americ				
9	after or Ite		1 Never Married 2 Married	Armed Forces	No		ryes, specnty (1 □ Yes 2 🛣			Hican, etc.)		ick, White,				
8	rel',	d by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		TO THE ZLA	No Spec	ciry:		Specif	y: Wh:	ite			
5	I within 72 hours iene. r then "neturel", ine Madical Exe	Completed	15. Decedent's (Specify only highest g			(Give	dent's Usual Oc kind of work do	ne durina r	nost of works	ng	16b. Kind of B	lusiness/in	dustry			
121	Mithir Den Chen	mp	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use re				0	TT				
22			17. Father's Name (First, Middle, Las	st)			Homemak		other's Name	(First Middle	Maiden Sumar	Home		_		
Maryland 21215-0036	D TO D	To Be	_ `													
7	d 2 should be th and Mental t7 le marked of treumatic ev	-	Elmer Lee Thomas Katherine Agnes Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig.													
	71 1 1 1 1		Carole G. Fowler	r/Daughter		8825	Manaha	n Dri	ve El	llicott	City, I	MD	21043			
Je,	- I 0 -		20a. Method of Disposition	_	20b. Plac	e of Dispo	sition (Name o	f	_	Date	20c. Location		own, State			
E			1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		9	-	•		2/27	/06	Wood1	awn.	MD			
Baltimore,	permit. Pag Department Important: I eny injury c		21. Signature of Funeral Service Licensee 22. Name and Address of Facility MacNabb Funeral Home, P.A													
<u>m</u>	88 5 5 8			regorchik			301 Fre	deric	k Road	Cator	nsville	, MD	21228			
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause y one cause on each	ed the death. line.						rest,		Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	allero	reletter	Co	ulion	eulan	- Drs	ine			Onset and Death			
	/Medical Examiner		resulting in death)	Due to (or a	s a consequer	nce of):							0			
	> = =	_	Sequentially list conditions,	b												
\ .	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (01 a	s a consequer	ice or):										
by.	be executed sicien and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or a	s a consequer	nce of):										
8760,	The law requires that the death certificate be executed to the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Sal		d												
9	ificate g physi as the	Physician/Medical		0.												
Box	eath certific attending p	7	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								23d. Da	ate of delive	ery			
	deati	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant	at time of deat	Other (specify		Mo	onth	Day Year						
P.0	at the de by the a stached	hys	9 Unknown 9Unknown													
	es that igned t	by	Part II. Other significant conditions	contributing to death	but not resulting	ng in the u	nderlying cause	given in Pa	art I.				he cause of death?			
ord	w requir been si should	ted								1 \	′es 2□No	3 Prob	pably 4 Unknow	vn .		
ec	e law has b	Completed								24a. Was autop	sy .	prior to co	psy findings availat mpletion of cause o	ole of		
<u>=</u>		S								1 Tes		dealh? 1 □ Yes	2□ No			
of Vital Records,	Phyaician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othor		(Check only o			Assiste	đ		
of	Phya rthis ral dii	은 :	1 ☐ Yes 2 ☑ No 27. Manger of Death	28a. Date of In		VOutpatier 3b. Time of	1 3 DON			me 5 Resid	lence 6 Oott	her (Specif	Living	<u> </u>		
	ding Ih. Th. After	ertification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, D	ay Year)	Injury		njury at Work? I □ Yes 2		200. 200011201	ow injury coods	100	O			
Division	l or Attending after death. Director: Afte d in by the fune	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Ir	njury - At home	e, farm, str	eet, factory, off	ce				ber or Rura	al Route Number,			
á	al or s afte of in b	Cert	4 Homicide	building, e	etc. (Specify)					City or Tou	n, State)					
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 € Certifying F	Physician: To the bes	t of my knowle	edge, deati	occurred at th	e time, date	and place,	and due to the	ause(s) and m	anner as s	tated.			
	To the H within 24 To the Fi	ledical	oney	eminer: On the basis and manner s	stated.	1 and/or in				ed at the time,	date and place,	and due to	the cause(s)			
	To To Con	Σ	29b. Signature and title of certifier	Λ				ense numb			29d. Date signe					
,	1		While I Will	info up			Do	14/	81		Februa	ry 24	, 2006			
	h		30. Name and address of person who	completed cause of	death (Item 23	3a) (Type,	Print) / 00 /	, ,	0,00	4-1-	Februa AVE	I	D 1/2	79		
.8	Sta	to	31. Date filed (Month, Day, Year)	32. Regis	trar's Signatur	θ	, 55 /		1116	1313	/11-	Pri	ע שואי	_/		
	Registr	-	FFR 2 8 21	Ins Files	4. K	Sol	calle									
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DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ırylan	-			lealth a			Reg. No.	11116	058	22				
	Physicia	an	Decedent's Name (First, Middle, Last)							2	2. Date of De Month	Day	/ Year		f Death				
	/Medic			Dorothy	E.	Gebe	lein				FEB	24		7:50	P M				
	Examin	er	4a. Facility Name (If not institution, give	4c.	County of De	ath													
			Westminster Nursi				(1)		minst				Carı						
	Funeral Director		5. Social Security Number 213-01-8113 6. Sex 1 I M 2 XF 84 Yrs. 6. Sex Months Days Hours Min. AUG 3, 19										(ear) 9. Birthplace (State or Foreign Country) 1921 Maryland						
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside C	City Limits				
	Man -f sh	to	MD Carro	11			1	Westm	inste	r				1 ☐ Yes	2 X No				
	r 28s	Funeral Director	10e. Street and Number				10f. Z	ip Code				10g. Citi	izen of What C	Country?					
	h wit	<u>e</u>	1234 Washington	Road					2115	7			USA	1					
	deat	ner	11. Marital Status	12, Was Decedent E Armed Forces?	ver in U	.S. 13.	Was Dec	edent of H	ispanic Orig	gin? (Speci	fy Yes or No	0-	14. Race - Am						
9	after or Ite	E	1 Never Married 2 Married	1 Yes 2 XN	lo			20XNo	Specify:	, rueno ni	can, etc.)		Black, Wh	ite, etc.					
8	iral',	db	3 Widowed 4 Divorced	Year or Dates:			10 103	244140	Specily.				Specify: V	Mhite					
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show he Marical Examinet must be multied at	Completed by	15. Decedent's Edu (Specify only highest grade			16a. Dece (Give	kind of v	rork done o	durina most	of working	7	16b. Ki	ind of Busines	s/Industry					
12	vithin ne. han	mpl	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.		use retired er Wo	´				Disab	lad.					
2	filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Last)				INE V	ET MO		de Nama (First, Middle	Maidan		red					
auc	htal Particularity	Be	William		Cal	belein					FIISI, MIDDIE	, машеп	Sumame)	TT .1					
Ž	should nd Men r marke umatic	2		O-i-+1	Gei			(C)	Em		2	- 0	- T O	Unk.					
Maryland	d 2 st th and 7 Is r traur		19a. Informant's Name/Relationship (Ty	-									r Town, State,						
	1 and Health em 27 ther tr		William J. Franz, 20a. Method of Disposition	guardian	20b. F	lace of Disp			s Mil	1 Roa			ocation - City o		-				
Baltimore,	Pages nent of I nnt: If its ury or o	ĺ	1 ☐ Burial 2 【XCremation 3 ☐ F	emoval from State	C	emetery, cre	matory or	other plac					,						
Ħ	it. Per rtmer rtant njury		'4 □Donation 5 □ Other (Specify)	• George		tro Cr							altimor						
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		21. Signature of Funeral Service License	Tir Shy	Haci	Nabb 2				OLC	mation load]	n Soo Balt:	ciety c imore.	f MD, I MD 212	nc. 228				
П			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each lin	Θ.		ter the m	ode of dyin	g, such as	cardiac or i	respiratory a	ırrest,		Approxima Interval Be Onset and	ite itween				
	Physician /Medical		disease or condition resulting in death)	Due to (or as		OB	21100	CITY	E 7 C	41/01	muy	DV	21 26	54eAu	0				
	Examiner	1		Due to tor as a	a conseq	derice or).													
	ad sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseq	uence of):													
	sate be executed oblysician and the burial-transit	xar		Due to (or as a	a conseq	uence of):													
760,	sician buria	cal E		,		,													
89	ficate p phy: ts the	edlo																	
Вох	nding use a	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1										elivery						
	death e atte d for	icla											Month	Day	Year				
0	t the cy the ache	hys	9 Unknown	9□ Unknown															
	Attending Physician: The law requires that the death certific r death. r death. ector: Affer this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as to the funeral director.	by P	Part II. Other significant conditions cor	ntributing to death bu	it not res	ulting in the u	undertying	cause giv	en in Part I.		23e. Did 1	tobacco u	use contribute	to the cause of	death?				
Ď	w require been sig should b										×	Yes 2	□ No 3 □ F	Probably 4 🗆	Unknown				
000	s bee	Completed									24a. Was		24b. Were a	autopsy findings	available				
Ä	The lay te has	mo									auto perfo	ormed? 2 A No	death?	completion of a	cause or				
ta	Physician: The l this certificate ha al director, page	0	25. Was case referred to medical						26. Place	of Death (Check only		1 ,0.0	3 20 110					
>	ysici is cei direc	To B	examiner?	lospital: 1 Inpatie	nt 2 🗆	ER/Outpatie	nt 3 🗆 (Oth	-				6 ☐Other (Sp	ecify)					
0	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Injur (Month, Day	y Year)	28b. Time o	of	28c. Injun Wor		1	d. Describe								
Ö	ath. r: Aff	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(1107111)	,	ii jui y	М		Yes 2 1	Vo									
Division of Vital Records,	l or Attending latter death. Director: After in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							f. Location (City or To			Rural Route Nur	nber,				
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the		(Check only 2 Medical Exami	sician: To the best oner: On the basis of	of my kno	wledge, deal	th occurre	d at the tin	ne, date and	d place, an	d due to the	cause(s)	and manner a	as stated.	s)				
	To the hwithin 24 To the F	Medical	one)	and manner sta	ted.														
1	With Co.	4	29b. Signature and title of certifier	~0 . —				9c. Licens 23(6					4	nth, Day, Year)					
F			I i firm co h. G	EDENE 14	_								125/201						
	/		30. Name and address of person who co	mpleted cause of de	eath (Iten	1 23a) (Type	Print)	ZW	2008	W	estmi	~576	ee m	aculand ?	11157				
	Sta Registr		31. Date filed (Month, Day, Year) FFB 2, 8, 2	32. Refistra	_	ature	book												

			For State Registrar		State	of Ma	rylan	-			lealth a		lental Hy	giene	11115	05	82	23		
	Physici	an	Decedent's Name (First, Manual Control of the										2. Date of D	eath Day	y Yea	ar l	me of I			
	/Medi		Pearl Elizab										Februa	_			35	Рм		
	Examir	ner	4a. Facility Name (If not insti Gilchrist Ce:				10		4b. City,	_	Location of	of Death			y of Death .timore					
			5. Social Security Number		Sex			ast birthday)	If Under		WSON	24 Hrs.	8. Date of Bi	rth			tate or	r Foreign		
5	Funeral Director		216 16 5576		1 ☐ M 2 🖾 F	82	()	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D Oct. 29	1927	3 77-	Birthplace (S Country) Lrgini		rologn		
9			Usual Residence of Deceder										500.25	1500						
35	show	-	10a. State 10b. Co Maryland Bal	,	25 0		10c. City	, Town or Lo								10d. Ins		y Limits 2 XNo		
	he M	ecto	10e. Street and Number	CIIIO	ie.			Essex		0.1-				10- 01			, 103			
60	wits after death with the Maryland rai; or itema 23e or 28a-f show Examinar must be notilited at	Funeral Director	70 Berkshire	Rd.					10f. Zip	212	21				izen of What USA	Country?				
	death ma 23	era	11. Marital Status	. Marital Status 12. Was Decedent Ever in U.S. 1								igin? (Sp	ecify Yes or N Rican, etc.)		14. Race - A		an,			
0 0	b 22	Ē	1 ☐ Never Married 2🔀	Married	Armed F 1 ☐ Yes If Yes, G	2 🔼 N	0	1	tYes, spec 1 □ Yes		ın, Mexicar Specify:		Rican, etc.)		Black, W Specify: Wh					
003	72 hours "natural",	d by	3 ☐ Widowed 4 ☐ Divo		Year or I	Dates:									Specify: ***					
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6,2006	be filed within 72 ho ital Hygiene. Id other than "natur event, the Medical	Completed	Elementary/Secondary (0-	12)	College	1-4or 5-	+)		sewii		,			Own	Home					
98	e filed I Hyg other	BeC	17. Father's Name (First, Mic	ddle, Las	it)						18. Mothe	er's Name	e (First, Middle	, Maiden	Sumame)					
Maryland		To	Harry O. Self								Pear	1 C.	George	3						
7	2 sho and is m	19a. Informant's Name/Relationship (Type, Print) Pearl E. Novotny (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town Pearl E. Novotny (Daughter) 20b. Place of Disposition (Name of Disposition (Name of Date 20c. Location														17	2261			
	t and tealth m 27 ther to		Pearl E. Novo	cny	(Daugnte	er)	20h Pi				Circ		nrewsbl Date			/Ivania 17361				
3 5	or or		1 ⊠Burial 2 □ Crema			20b. Place of Disposition (Name of cometery, crematory or other place) Holly Hill Mem. Gardens 3,									imore			ď		
ebous	permit. Pages 1 and 2 Depertment of Health a important: if item 27 is any injury or other tra ance.		4 □Donation 5 □Oth 21. Signature of Funeral Se			0	1101				i i				· ·	· · · · · ·				
_	permit. Dependimport		bahn W.	K	WERMIN	160	,	E 1	ruzdz 407	insl	ki Fu Faste	nera rn A	l Home Venue H	P.A.	. Mary	zland	212	21		
(10			23a. Parl1. Enter the diseas shock, or heart failure.	e, or co	mplications that	caused	the death									Appro	ximate al Betw)		
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	/Medical Examiner		resulting in death)	-	a Due to	(or as a	consequ	ience of):			- / \					110	70	1000		
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الما	be executed sician and burial-transit	xar	that initiated events resulting in death) Last		c. Due to	(or as a	consequ	ience of):				-				-				
760	ite be executed ysician and ne burial-transi	call		•	d															
			IS EEMALE.																	
Box 68	death certifica	by Physician/Med	IF FEMALE: 23b. Was decedent pregnar in the past 12 months?		23c. If yes, ou 1□Live		of pregnar 2 Fetal		Ectopic pr	egnancy				18	23d. Date of Month	delivery Day	~	ear		
^ 0	. 5 65	ysic	1 ☐ Yes 2 No 9 ☐ Unknown		4□Preg 9□Unkr		lime of de	eath 5□	Other (sp	ecify)					Wiona	Day		oai		
0	es that thighed by be detac	Ph.	Part II. Other significant con	nditions	contributing to d	death bu	t not resu	ilting in the ur	nderlying c	ause give	en in Part I.		23e. Did	tobacco u	ise contribute	to the caus	e of de	eath?		
Seconds.	The law requires that the tew second of the												10	Yes 2	% 0 3 □	Probably	4 □Ui	nknown		
()	w requ	olete											24a. Was		24b. Were	autopsy find	lings a	vailable		
	The lav ate has page 2	Completed											auto perf	ormed?	death	to comptetion ? 'es 2 □ No		use of		
Vita	iclen: Th certificate rector, pag	Bec	25. Was case referred to me examiner?	dical						_	26. Place	of Deatl	Check only							
ر و لــ	Physicle this cert at direct	မ	1 ☐ Yes 2 No					ER/Outpatien			4 1110	_	me 5□Res		-	pecify)	20	pice		
	h	lon	27. Manner of Death 1 Natural 5 □ P		28a. Date (Mor	of Injury	Year)	28b. Time of Injury	2 М	8c. Injury Work			28d. Describe	how injur	y occurred		V			
CFR Division	ttend death ctor: /	licat	3 ☐ Suicide 6 ☐ C	vestigati ould not	be co. plan	e of Iniu	rv - At ho	me, farm, str			Yes 2		28f. Location	Street an	d Number or	Rural Route	Numb	ner .		
O E	al or A after i Direct	Certification:	4 Homicide	etermine	build	ling, etc	(Specify)	001, 100101)	, othog			City or To			110,01110010	7.07.10			
0	To the Hospital or Attention within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Cer (Check only 2 Med	tifying F dical Ex	Physician: To the training: On the training man	pasis of	examinat	wledge, death ion and/or inv	occurred restigation	at the tim	ne, date an pinion, dea	d place, th occur	and due to the red at the time.	cause(s)	and manner place, and o	as stated. Jue to the ca	use(s)			
	To the within To the comple	W	29b. Signature and title of ce	entifier	mill	L	7,6	no			520	5		29d. Dat	Signed (Mo	onth, Day, Ye	iar)	006		
	12		30. Name and address of pe	rson wh	Completed cau	se of de	ath (Item	23a) (Type,	Print) Ch	nl	es S	H	Pols	6. 10	ns:	2120	1 8	:		
	Sta		31. Date filed (Month, Day,	(dar)	32	Règistra	r's Signat	ure do	Well.											
	Regist	al	FFB 2	8 2	006	Splan	9 50	1					<u></u>							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2 Physician 2006^{ar} 25 11:15a м Goodwin Charles /Medical 4c. County of Death NA 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 1202 Valley Street If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** t**X** M 2□ F 219-66-7764 Yrs. Director 13 Md. 51 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 XYes 2 ☐ No Director Baltimore NA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 21202 1202 Valley Street Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: Black δ permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural!, any injury or other traumatic event, Ita Medical Exagnes. 3 ☐ Widowed ♣ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Invironmental Services 9th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marie Goodwin Linton ပ္ Iassac 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1202 Valley Street, Baltimore, Md. Daughter Tiffany Goodwin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation √5 ☐ Other (Specify) King Mem. Pk. 3-4-06 Randallstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 Baltimo 1101 E. 1

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Ave. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Livonthi Non /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certiticate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one) examiner? Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Atter 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: in by the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Roule Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide hours after To the Hospital c within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death conumed at the time, date and place, and due to the nausa(s) and via ner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 27 200g 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATIMORE MD 21204 CHARLIES 6601 N. Charles 31. Date filed (Month, Day, Year) 32. Signature State Registrar 2006

DHMH 17 Rev 1/2001

68760.

Box (

ivision of Vital Records.

LOORINIA

		•	For State Registrar	State of	Maryland		artment <i>rtificate</i>			Mental Hy	giene Reg No.	006	05825
	Physici		1. Decedent's Name (First, Middle, RD V		ZNER					2. Date of D Month FEB 20	Dav	Year 2006	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, o	give street and nun		AL	4b. City. To	own, or Los	cation of De			County of Deat	
	Funeral Director		1 71		7. Age (In yrs. la		If Under 1 Months		Under 24 H lours M	rs. 8. Date of Bi	rth a <i>y, Year)</i> 7–18	9. Birt	hplace (State or Foreign untry)
	Maryland I-f ehow	ō	Usual Residence of Decedent 10a. State 10b. County			, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the a or 28s	Funeral Director	Md. Balti 10e. Street and Number 7925 Stevenson			PIK	esvill 10f. Zip C 21				-	zen of What Co	
36		by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Fo	2 No		Was Deceder	Cuban, N	nic Origin? Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)		4. Race - Ame Black, White Specify: B	
21215-0036	"na"	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		-4or 5+)	(Give life.	dent's Usual kind of work DO NOT use CK Dri	done durir retired)	n ng most of v	vorking		and of Business/	industry
Maryland 2	ould be filed within Mental Hygiene. arked other then setic event, tre M	To Be Co	8th grade 17. Father's Name (First, Middle, La William	st)	Garne		CK DII		Mother's N	lame (First, Middle			
	ss 1 and 2 should be of Health and Mental item 27 is marked c other treumetic eve		19a. Informant's Name/Relationship Roosevelt Flech		riend	792	5 Stev	ensor		Rural Route Numi Pikesvi	lle,	Md. 2	1208
altimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	cify)	State	netery, creadon P	osition (Name matory or oth	er place) em.	1	-28-06	Bal	cation - City or	, Md.
Bal	Departr Departr Importr eny inj		21. Signature of Fureral Service Lie				March	F.H.	East	1101	E. N	re, Md. North Av	21202 Ve. Approximate
8760,	Physician /Medical Examiner physicien and ph	dicai Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ATH Due to (ach line.	LERO ence of):				4 SCULLA		EAJE	Interval Batween Onset and Death
Box 6	The law requires that the death certifics to has been signed by the attending phoage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live b	come of pregnar irth 2 Fetal ant at time of de own	death 3[⊒Ectopic preç ∃ Other (s <i>pe</i> c				2	3d. Date of del Month	ivery Day Year
rds, P.0	w requires that t been signed by should be detar	þ	Part II. Other significant condition	s contributing to de	eath but not resu	iting in the u	inderlying cau	ıse given i	n Part I.		tobacco us		the cause of death?
al Reco		Completed								24a. Wa auto per 1 🗆 Yes		24b. Were au prior to death?	atopsy findings available completion of cause of 2 100
of Vita	Attanding Physician: 7 death. r death. ector: After this certifical by the funeral director, p	n: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death			P/Outpatie		Other	4 🗆 Nursin	Death (Check only G Home 5 Res 28d. Describe	idence 6		cify)
Division of Vital Records,		Certification: To	1 Watural 5 Pending 2 Accident 3 Suicide 6 Could no 4 Homicide	tion t be 28e. Place	of Injury - At hong, etc. (Specify	Injury me, farm, st	М	1 🗆 Yes	2 □ No		(Street and own, State)		ural Route Number,
	To the Hospitei or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only 2 Medical S:	Physician: To the seminer: On the band man	best of my know asis of examinat ner stated.	vledge, deat ion and/or in	ivestigation, in	n my opini	on, death or	ace, and due to the courred at the time	, date and	place, and due	to the cause(s)
	o Tairt	2	29b. Signature and title of certifier	Kota	m, mo		1	License nu	(8)		_	e signed (Mont	
le g	Sta	te	30. Name and address of person w MUMAGE ROT 31. Date filed (Month, Day, Year)	HIKIM S	e of death (Item	M C	Print)	ROA	DR	ANDALLS	TOU	W, MAS	2 / LAND 21133
DH	Registi	ar	FEB 2	8 2006	Magness	AS.	Souls.	-					

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ORIGINAL

CFF 06-01407 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Unpend item#1, 23a-b,27,pen/#1,853,3/22/06 []]

State of Maryland / Department of Health and Mental Hygiene Rose Lee Gavigan 1 - For State Registrer Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Rosie Lee Gavigan 2006 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Center Chestertown Kent 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Nonth Days Hours Min. Birthplace (State or Foreign Country)
 Md 5. Social Security Number 8. Date of Birth (Month, Day, Mar 25 **Funeral** 1947 1 □ M 2 🟋 F 58 213-46-5848 Yrs. Mar Director Usual Residence of Decedent the Maryland 10c. City, Town or Location Centreville 10d. Inside City Limits or 28a-f show r than "natural", or items 23a or 28a-f eho: the Medical Examiner must be notified at Md Oueen Anne 1X Yes 2 □ No Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 311 Little Kidwell Avenue 21617 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. housekeeper home maintenance 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ith and Mental F 27 ie marked of treumatic aver Pages 1 and 2 should be Alma Mae Anderson Bee Horace Nida 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21617 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Depertment of Heetth ar Important: if Itam 27 te any injury or other treu 311 Little Kidwell Ave., Centreville, Md Joey Gavigan (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-2-06 Crest Lawn Mem. Marriottsville, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Jage of orgent of enternt P.O. Box 195 Sykesville, Md 21784 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary artery thrombosis /Medical Due to (or as a consequence of): Examiner Arteriosclerotic cardiovascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9□ Unknown bengis Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 2 No Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 XYes 2 ☐ No After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter or To the Funeral Direct completely filled in by 4 Homicide 29a. Certifie 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signatore and title of certified Keney O.C.M.E. February 26, 2006 nd address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) FEB 2 8 2006

LAREN WC

2. Registrar's Signature

Joseph

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 25, 2006 Frank Benjamin Giordano 4:07 Ρм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice Casey House Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F September 18, 1911 94 163-10-4094 Yrs. Director Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-1 show the Modical Examinar must be notified at Maryland 1 ☐ Yes 2 K No Montgomery Potomac Direct 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 9441 Copenhaver Drive 20854 United States death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Item any injury or other traumatic event, the Moulcal Examinar, page. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Civil Servant Department of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Vincenzo Giangiordano Nicetta Barone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Argentiero / Daughter 9441 Copenhaver Drive, Potomac, Maryland 20854 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Place on Community Commetery Cross
Cemetery
Canada Address February 28, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Yeadon, Pennsylvania 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, M01420 300 West Montgomery Avenue, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Debility Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ig physicien and as the burial-transit be executed Chronic Renal Failure Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medicai sate has been signed by the attending page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 20 No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospice 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 🗌 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D35635 February 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Joseph Kaplan, M.D.

2006

31. Date filed (Month, Day, Year)

32. Begistrar's Signature

6001 Muncaster Mill Road, Rockville, Maryland

			For State Registrar	State of Ma	ıryland			t of He		nd Me		iene	16	0582	8
	Physici /Medic			DORIS L	OUISE	. GR	OVE			F	2 Date of Deat Month EBRUAR	Y 26,2		3. Time of Do 7:35 P.	
	Examin	er	4a. Facility Name (If not institution, give s 8149 LOCH RAVEN B	OULEVARD				TOWS				4c. Count		TIMORE	
45 6 2 2	Funeral Director		177 10 2333	V. W	e (In yrs. Ia. 83	st birthday) Yrs.	If Unde Months	1 Year Days	If Under 24 Hours	4 Hrs. 8	8. Date of Birth (Month, Day, 08-26-1	922		hplace (State or F DUNTY) NINNESOTA	
	h the Maryland rr 28a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County	ORE	10c. City,	Town or Lo	cation	TO	OWSON					10d. Inside City	
	death with the Maryland rms 23s or 28s-f ehow	i Director	10e. Street and Number 8149 LOCH RAVEN	BOULEVA	RD		10f. Ziş		L286		1	0g. Citizen of	What Co	•	
036	urs after death al', or items 23 Examinar mus	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married XX □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2XXV tf Yes, Give Year or Dates:		l II	Vas Dece Yes, spe	cify Cuban	spanic Origi n, Mexican, Specify:	in? (Spec Puerto R	ofy Yes or No- lican, etc.)	14. Ra	ce - Ame ack, Whit	erican Indian,	
9500-91212	filed within 72 hours after Hygiene. other than "natural", or ite ent, the Madical Examina	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12 YEARS		+)	16a. Deced (Give life. L ASST.	kind of wo	ork done di se retired)	uring most o		g	CHURCH		OSPITAL	
Maryland	should be file ind Mental Hy s marked oth umatic event	To Be (17. Father's Name (First, Middle, Last) CARL	GOSLING						's Name ((First, Middle, M ROSE	Aaiden Suma NFELD	me)		
	haha 7 li	3	19a. Informant's Name/Relationship (Ty CAROLYN L. HEFTY	рө, <i>Print)</i> (DAUGHTEF		8149	LOCH	RAVE			Route Number			Zip Code) ID,21286	
altımore,	Pages 1 and nent of Healt ant: if item 2 ury or other	1	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	emoval from State	cer	netery, crem LTOP S	natory or c	me of other place CE CC	ÖRP. 0	Da 12-28	8-2006		,MAR	YLAND,21	204
Balt	permit. Pag Department Important: it eny injury o once.		21. Signature of Funeral Service License		.RUTH				s of Facility N FUNE		HOME, IN	10	50 YC VSON,	ORK ROAD MD.21204	
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.O. Box 68760	law requires that the death certificate I as been signed by the attending physi 2 should be detached for use as the t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 Fetal o	death 3□	Ectopic p					\$	ate of dei	ivery Day Yea	ar
ds, P	uires that signed b Id be deta	by	Part II. Other significant conditions cor	ntributing to death bu		fing in the ur	nderlying	cause give	n in Part I.		23e. Did tob			o the cause of dea robably 4 🗍 Uni	
Vital Records,	The ate h page	Completed									24a. Was all autops perform	24b.	death?	utopsy findings avacomptetion of cau	ailable se of
Division of Vita	To the Hospitel or Attending Physicien: The within 24 hours alone death. To the Funerel Director. After this certificate completely filled in by the funeral director, pages.	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 Inpatier 28a. Date of Injur (Month, Day	y 2	R/Outpatien 28b. Time of Injury		28c. Injury Work	r: 4 🗆 Nurs	sing Hom	(Check only on e 5 Reside 3d. Describe ho	ince 6 🗆 Ot		cify)	
DIVIS	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, efc	iry - At hom :. (Specify)	ne, farm, stre	eet, factor	y, office		28	Bf. Location (St. City or Town		ber or Ri	ural Route Numbe	r.
	ne Hospit n 24 hours ne Funere pletely fille	edical (29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	ner: On the basis of and manner sta	examination	on and/or inv	estigation	i, in my op	inion, death	occurred	d at the time, da	ate and place	, and due	to the cause(s)	
)	To the To the Comp	Σ	29b. Signature and title of certifier Fin BBW	a, M)			29	c. License	number 0	1	2!	9d. Date sign	ed (Mont	h, Day, Year) DÇ	
	H		30. Name and address of person who co	mpleted cause of de	eath (Item :	23a) (Type,	Print) Ponu	ment	-54,	Rm	8068	Baltin	none	h, Day, Year) DG MD 217	287
7	Sta Registr	2	31. Date filed (Month, Day, Year) FEB 2 8 2006	32. Registra	ar's Signatu	ire Jose	de								

State of Maryland / Department of Health and Mental Hygiene () 05829 For State Registrar Certificate of Death Rag. No 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death FEBRUARY 24, 2006 **Physician GERSHANOV FOMA** 2:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUN.29, 1918 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Months Days Hours BELARUS Yrs. 87 Director 217-39-5990 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28e-f shov traumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21215 Items 23a 5900 PARK HEIGHTS AVENUE #201 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ☐ Never Married 2 X Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) BUILDER BUILDING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fi ment of Health and Mental H tent: If item 27 is marked otl GERSHANOV LETBA (UNKNOWN) LAZAR ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5900 PARK HEIGHTS AVENUE #201 - BALTIMORE, MD 21215 RAKHEL GERSHANOVA / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or QDCC. ARLINGTON CHIZUK AMUNO 2/26/2006 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 sease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, flure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the o Atherosc Immediate Cause (Final **Physician** disease of condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 2 No 1 ☐ Yes 1 Tyes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Surring Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier (Sychrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 9 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

Sersh Anou

P.O. Box 68760.

Zachary Green 06-01207 dl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible pend item# 23a, PIL, 27, pen/e, 2833, 3/2//00 II

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	Director		Usual Residence of Decedent			115.	3	9			Nov 7	200)5 Mar	yland
	yland how		10a. State 10b. County		-	, Town or Lo								10d. Inside City Limits
	Ba-fa	ctor	Maryland Anne A	rundel		Annap						_		¥∰ves 2 □ No
	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Itams 23a or 28a-f ahow ther than Medical Examinar must be notified at	Funeral Director	10e. Street and Number 1257 Stonewood	C+			10f. Zip	Code 2140	10			10g. Cit	izen of What Cou USA	untry?
	ns 234	eral	11. Marital Status	12. Was Decedent E	ver in U.S	S. 13. \				gin? (Spe	ecify Yes or No- Rican, etc.)		14. Race - Amer	ican Indian,
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Maryland 21215-0036	C1 60 = 60		19a. Informant's Name/Relationship (Brian Green (Fa	• •			_					-	or Town, State, Z. S, Md.	
	t and Heaith tem 27 other ti		20a. Method of Disposition		20b. Pf	ace of Dispo	sition (Nam	e of	1		ate		ocation - City or 1	
E O	Pages ient of nt: If i		1 ☐ Burial 2 XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			emetery, crer tro C				2-21	-06 F	a1t	cimore,	Md.
Baltimore,	permit. Pages to Department of Figure 1 important: If ite any injury or ot once.		21. Signature of Funeral Service Lice	Pease Mol	49	2 8	Name and M · Re	Address	s of Eacitit	Sons	Mortu	ary	7, P.A.	0.1
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Box	ires that the death cert signed by the attendin d be detached for use	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic pre						23d. Date of deli- Month	very Day Year
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o	문 두 필	l His	27. Manner of Death	28a. Date of Injur (Month, Day		28b. Time o Injury		Bc. Injury Work			28d. Describe I			,
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Division of	or Att fer de Jirect in by t	Certification;	3 Suicide 6 Could not to determined				eet, factory	, office			28f. Location (S City or Tox	Street al vn, State	nd Number or Ru e)	ral Route Number,
	pital ours a cours a c		29a. Certifier 1 ☐ Certifying P	hysician: To the best of	of my know	wledge deat	h occurred :	at the tim	e date an	nd place :	and due to the	cause(s	and manner as	stated
	To the Hospital or Attendity within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		miner: On the basis of and manner sta	examinat									
	To the within To the comp	ž	29b. Signature and title of certifier				29c	. License	number			29d. Da	ite signed (Monti	n, Day, Year)
			I hij hi	mis			0	CME				Feb	ruary 17	7, 2006
			30. Name and address of person who		eath (Item	23a) (Type,		Derr	C+	. a t	Do1+4	 ~	Mo1	A 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ture /		renn	stre	et,	Daltimo	re,	Marylar	IU 414UL
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			For State Registrer	State of	Maryland		artment of H		Mental Hy	giene	006	05832		
			1. Decedent's Name (First, Middle,	Last)					2. Date of De	aath		3. Time of Death		
	Physici /Medic		MILDRED				HULLER		Month 02	Day 24	2006	10:25 P™		
	Examin		4a. Facility Name (If not institution,	give street and num	ber)		4b. City, Town, or	r Location of Dea	ith		County of Death			
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	within 72 hours after death with the Maryland ene. than "neturel", or itams 23a or 28a-f show the Madical Everiliner must be notified at	Funeral Director	17 Gyro Driv	70			10f. Zip Code 21220			USA	zen of What Cour	ntry?		
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8	al', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	tes:		1 ☐ Yes 2 🔀 No	Specify:			Specify: Whi	te		
2-0	72 ho	ted	15. Decedent's (Specify only highest	Education		16a. Deced	lent's Usual Occupa	ation	adria a	16b. Ki	nd of Business/In	dustry		
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Maryland	12 sho th and 7 is mu trauma		19a. Informant's Name/Relationshi Craig Huller				g Address <i>(Street a</i> LittleR					Code)		
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altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy fulry or other traumatic event, It a Madical Exercites must be notified at once.		1 Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		tate Park	etery, crer.	atory or other place ICemeter	y 2/	28/06		timore			
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Вох	certi nding use a	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregnancy	y					23d. Date of delive	an/		
ğ	death a atte	cial	in the past 12 months?	4 ☐ Pregna	th 2 Fetal de nt at time of deat		Ectopic pregnancy Other (specify)			'	Month	Day Year		
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ď	w require been sig should b	ed k	congolar L	int for	luc				1 🗆	Yes 2	□No 3 □ Prob	ably 4. Unknown		
Vital Records,	The law requires that the death certify the law requires that been signed by the attending page 2 should be detached for use as	Completed							24a. Was		24b. Were auto	psy findings available		
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ta		BeC	25. Was case referred to medical					26. Place of De	eath (Check only			20110		
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n of	ding Ph h. After thi funeral		27. Manner of Death ➤ Natural 5 ☐ Pending	28a. Date of	Injury 28 , Day Year)	Bb. Time of	28c. Injury Work	/ at	28d. Oescribe					
Sio	andii eath. or: A he fu	catic	2 Accident Investiga	tion				Yes 2 □ No						
Division	fter direct	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	288. Place (of Injury - At home g, etc. <i>(Specify)</i>	, farm, str	eet, factory, office		281. Location (City or To	Street and wn, State,	d Number or Rura)	l Route Number,		
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	To the Hospital or Attanding within 24 hours after death. To tha Funaral Director: After completely filled in by the funer	edicai	29a. Certifier 1 Certifying (Check only one) 1 Certifying 2 Medicel 8	Physicien: To the baseminer: On the base	sis of examination	age, death and/or inv	occurred at the time of the time of the control of	ne, date and plac pinion, death occ	e, and due to the curred at the time,	cause(s) date and	and manner as si place, and due to	tated. the cause(s)		
	o the	Med	29b. Signature and title of certifier	2.12 1121111			29c. License	number		29d. Date	e signed (Month,	Day, Year)		
	F S H Ö		D. 0 <	D			033	790						
	1		30. Name and address of person w	ho completed cause	of death (Item 2:	3a) (Type.		-/)		()	CUACY 23	, 200		
			DR. DAVID DUNN,		-		•	R, MD 2	1014					
	Sta		31. Date filed (Month, Day, Year)	32. Se	gistrar's Signatur	Э								
	Registr		FEB 2 8	ZUUb A	Essen St.	All	ents.							
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			State of Maryland / D	epartment of	Health a	•	giene 06	05833
			Registrar	Certificate of	Death		Reg. No.	
4	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	Day Year	3. Time of Death 10:00am
	/Medic	al	Walter L. Hands Jr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town,	or Location of	Feb.	20 2006 4c. County of Deat	
1	Examin	er	30 Rockywood Lane		sex	Dodin		
100	Funeral	3216 ·	5. Social Security Number 6. Sex 7. Age (In yrs. last birti	hday) If Under 1 Yea	r If Under 2		Baltir 9. Birt	no re hplace (State or Foreign buntry)
· 46	Director		213-32-3555 1 ¹ / ₂ ^{M 2□} F 69	rs. Months Days	s Hours	July 9	1936 Ma	ryland
	p ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
	shov shov	ក	MD Baltimore	Essex				1 Yes 2 No
	28a-f	Director	10e. Street and Number	10f. Zip Code			10g. Citizen of What Co	ountry?
	3a or		30 Rockywood Lane		21221			
	death ms 2:	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces?			n? (Specify Yes or No- Puerto Rican, etc.)	USA 14. Race - Ame	
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9	filed within 72 hours after death with the Maryland Hyljohe. Nitar than "natural", or Items 23a or 28a-f show Nit, i.e. Medical Examinar must be rollified at	d by	3 Wildowed 4 Divorced Year or Dates:				Specify: Wh	
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<u>lar</u>	uld be Aental rked o tic eve	To B	Walter L. Hands		Mar	y F. Feeb	le	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar I Healith and Marylar lates and lates and 19 speed them 23a or 28a-f show them 21a narked other than "natural", or Items 23a or 28a-f show other traumatic event, I'm Medical Frank at most ke notified at		19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Stree	et an <i>d Numb</i> er	or Rural Route Numbe	or, City or Town, State, 2	Zip Code)
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00	Pages 1 nent of H int: if Ital	-	1 Seurial 2 Cremation 3 Demoval from State	Disposition (Name of y, crematory or other pl			20c. Location - City or Baltimore	
Baltimore,	it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (Specify) 21. Signatura of Funeral Service Licensee	HillCemet		2/23/06		
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	w 17		23a. Part1. Enter the disease, or complications that caused the death. Book shock, or heart failure. List only one cause on each line.	ot enter the mode of dy	ace AV ying, such as c	e. Baltir ardiac or respiratory ar	nore MD 2	Approximate
200	Physician		Immediate Cause (Final					Interval Between Onset and Death
100	/Medical		disease or condition resulting in death) a. Congestive Due to (or as a consequence of	_Heart_Fa	ailure			
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T	pe ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	if):				
V	and I-tran	Examiner	that initiated events resulting in death) Last c. Chronic Ob Due to (or as a consequence of	structive	e_Pulm	onary Dis	sease	
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Ö	been	etec	Hypertension			24a. Was	an 24h Ware au	utopsy findings available
Rec	he lav	Completed	Seizure			autop perfo	osy prior to death?	completion of cause of
Vital Records,	ilcian: Th certificate rector, pag	a a	25. Was case referred to medical Transient Ische	mic Attac	ck	1 ☐ Yes of Death (Check only o		2 □ No
	Physicii this cer al direct	ToB	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA			lence 6 Other (Spe	city)
0 0	ng Ph fter th neral	:uc		ime of 28c. Inj			now injury occurred	
Sio	tendii eath. or: A the fu	catle	2 Accident investigation		☐ Yes 2 ☐ N			
Division of	or At litter d Direct in by	Certification:	4 Homicide 4 Homicide 4 Homicide 4 Sea Place of Injury - At home, fair building, etc. (Specify)	m, street, factory, office	e e	28f. Location (S City or Tox	Street and Number or Ri vn, State)	ural Houte Number,
	e Hospital or Attending I 24 hours after death. e Funeral Director: After etely filled in by the funer		29a. Certifier 1☆ Certifying Physician: To the best of my knowledge	, death occurred at the	time, date and	place, and due to the	cause(s) and manner as	s stated
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after dash. To the Funeral Director: After this certificate has been signed by the attending ph To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Medicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge 2 ☐ Medical Examiner: On the basis of examination and and manner stated.	Vor investigation, in my	y opinion, death	occurred at the time,	date and place, and due	to the cause(s)
	To the within 2 To the complet	¥	29b. Signature and title of certifier		nse number		29d. Date signed (Mont	P
•			fon stel theor mit	, P	5688	3 0	02/0	1/2006
	6		30. Name and address of person who completed cause of death (Item 23a) (D-11'			
5.0			Dr. Mian 9114 Philadelph 31. Date filed (Month, Day, Year) 32. Begistrar's Signature		Da⊥t1	more MD		
	Sta Registr		FER 2 8 2006 A Server J.	book				
			- FF (0 / HIII					

DHMH 17 Rev 1/2001

Registrar

		-	-	State of Marylan	d / Depa		ealth a				058	35
76. 5	le le	lar.	Decedent's Name (First, Middle, Last)					2. Date of De		. V	3. Time o	Death
	Physicia		Harry	L.		Hunter		Februai	cy 24	2006	6:40	РМ
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of	of Death	4c.	County of Dea		
-	LAGITIE	e.	Carriage Hill Be			Bethesd	а		Mo	ntgomer	У	
7	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. B. Date of Bi Min. (Month, D March	rth av. Year)	9. Bir	thplace (State ountry)	or Foreign
1	Director	8	512-12-5756	M 2□F 82	Yrs.	Wortens Day's	110010	March	7, 1	923 Ka	nsás	
	P		Usual Residence of Decedent	10c Cit	v. Town or Lo	postion					10d. Inside C	lity Limits
	anylar	<u>_</u>	Maryland Montgomer	y 100. Cl	Bethes							2 🔀 No
	8a-f	cto				101 71 011			10- 04	izen of What C	auat= .2	
	vith th	Director	10e. Street and Number 5600 Albia Road			10f. Zip Code 20816			-	ted Sta		
	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f ehow the Majical Extending the statistical et	Funerai			C 13			nin? (Specify Ves or N		14. Race - Am		
	er de	nue	T. Pictical Contract	2. Was Decedent Ever in U Armed Forces?	.5. 15.	If Yes, specify Cuba	n, Mexicar	gin? (Specify Yes or N n, Puerto Rican, etc.)		Black, Whi	te, etc.	
36	', or	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Styles 2 No 942 If Yes, Give Year or Dates: 1967		1 ☐ Yes 2 🗷 No	Specify:			Specify: W	hite	
Ş	hour ture	be	15. Decedent's Educ		16a. Dece	dent's Usual Occupa	ation		16b. K	ind of Business	/Industry	
5	in 72 " n	Completed	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	during mos i)	t of working	į			
72	with iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Ph	ysician			M	edical		
פ	othe othe	Bec	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name (First, Middle	e, Maiden	Sumame)		
a	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23a or 28a-f show or other traumatic event, it a Medical Examination in the notified at	To B	Adolphus 0.	Hunter			Ma	ıry	W	hite		
ary	shound N		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Street	and Numbe	er or Rural Route Numi	ber, City o	or Town, State,	Zip Code)	
Ž	nd 2 alth a 27 ls		Emily F. Hunter/Wi	fe	5600	Albia Ro	ad, B	ethesda, M	ary1a	and 2	0816	
ē,	s 1 a of Hear		20a. Method of Disposition		cemetery cre	osition (Name of matory or other place	:e)]	February	20c. L	ocation - City o	r Town, State	
Ē	Page ent c nt: If ry or		1 ☐ Burial 2 【本Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	110	ntgome emator	ry ium. Inc.	2	28, 2006	Bet	hesda,	Marylan	nd
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is eny injury or other tra 800.		21. Signature of Funeral Service License		2 D	2. Name and Addres	ss of Facili	v Robert A. Chase, Inc	Pum	phrey F	uneral	Home
Ä	Depa Impo eny iu		John & Chap	₩ M00092	В	ethesda-c	Maryl	and 20814	• //	J/ WISC	OUSTH E	venue
1880	Physician /Medical Examiner	9r	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	Aspiration Due to (or as a consect Dvsphagia	Pneum						Interval Be Onset and	tween Death
	nsit	i.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Parkinson'	s Dise	ase						
	le be executed ysicien and e burial-transit	Examine	resulting in death) Last	Due to (or as a consec	quence of):							
760,	sicie	call	U d									
89	ificate g phy ss the											
P.O. Box	it the death certificate be executed by the attending physicien and tached for use es the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	□Ectopic pregnancy □ Other (specify)	·			23d. Dale of de Month	elivery Day	Year
	ge ge ⊒	by Pt	Part II. Other significant conditions con	tributing to death but not re	sulting in the	underlying cause giv	en in Part	1. 23e. Did	tobacco	use contribute	to the cause of	death?
rds	n sign	D D	Acute Gastrointest	inal Bleedin	g, Ane	mia		1	Yes 2	√2No 3□F	Probably 4]Unknown
of Vital Records,	w requ	Completed						24a. Wa		24b. Were a	autopsy findings	s available
Re	The lav	E C						per	opsy formed? 2 🙀 No	death?		cause or
la		Ö	25. Was case referred to medical				26. Plac	e of Death (Check only				
5	Physicien: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 🖾 No	ospital: 1 Inpatient 2	ER/Outpatie	ent 3 DOA Oth	er: 4XN	ursing Home 5 Re	sidence	6 ☐Other (Sp	ecify)	
	ding Phy h. After this funeral c		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time		y at	28d. Describe	a how inju	iry occurred		
on	ding th. Afte	흹	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day real)	Injury		Yes 2]No				
Division	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec		treet, factory, office	-		(Street a own, Stat	nd Number or I e)	Rural Route Nu	mber,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Phys 2 ☐ Medical Examin	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, dea ation and/or i	ith occurred at the til nvestigation, in my c	me, date a ppinion, de	nd place, and due to th ath occurred at the time	e, date an	id place, and di	ie to the cause	(s)
	To the To the Comp	Σ	29b. Signature and time of certifier	1		29c. Licens				ate signed (Moi		
			1/m/V)	D3557	9		Febr	uary 27	, 2006	
	14.		30. Name and a dress of person	mpleted cause of death (Ite	m 23a) (Type	, Print)						
	(01)		Susan J. Miller, M			1 Terrace	, Bet	hesda, Mar	ylan.	d 2081	6	
S. 3		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sigr	nature	Land B						
相	Regist	rar	FEB 2 8 20	06	DE S	A STATE OF THE PARTY OF THE PAR						
DI	HMH 17 Rev 1/2	2001		0								

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month. 0 Earle W. Hosmer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Longview Nursing Home Manchester Carroll If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 157 M 2□F Yrs 89 Director 214-05-3952 Feb 3, Ohio Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County rei', or items 23a or 28a-f show Examiner a ust be notified at 1√2 Yes 2 No MD Baltimore Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7429 Berkshire Road 21224 filed within 72 hours after death Funeral USA12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white ğ 3 Widowed 4 □ Divorced "naturei" Completed the Mudical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 0 paint contractor self employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental Pages 1 and 2 should be is marked William Hosmer 2 Sylvia Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Carole Burton/niece permit. Pages 1 and:
Department of Health
importent: if item 27
any injury or other tr 8368 Blooming Grove Road Glen Rock, PA 17327 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ronald 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director 2000 23a. Part 1. Enter the disease, or complications that caused it shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed neumore -tran ue to (or as a consequence of): physician ar Box 68760, by Physiclan/Medical attending physic IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a o. 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown been si should l Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s autopsy performed 2[] No 1 Yes 2 **2**No 1 Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 tnpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 🗷 No ဥ 4 Nursing Home 5 Residence 6 Other (Specify) this erei Director: After th 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a

To the Funerei t

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier of death (Item 23a) (Type, Print) 688 People Road 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 8 2806 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:15 PM M Edmond Carlton Hutchinson Sr. February 21, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rebecca House Potomac Montgomery 8. Date of Birth (Month, Day, Year) 11/23/1913 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours 1₺M 2□ F Months Days 92 415-09-0674 TN Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location worle ! 10d. Inside City Limits me 23a or 28a-f ehov 1 ☐ Yes 2 ☑ No Montgomery Kensington Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9619 Hullridge Dr. 20895 USA Funerai Iteme 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian r than "natural", or Iter is 1 and 2 should be filed within 72 hours after of Health and Menial Hygiene.
Item 27 is marked other than "natural", or Itel other traumatic event, the Miccical Exeminat Black, White, etc. 1 Yes 2V If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify:Caucasian 3 Widowed 4 □ Divorced ted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Complet U. S. Government Elementary/Secondary (0-12) College (1-4or 5+) 5+ Economist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lawrence E. Hutchinson Susan McFerrin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edmond C. Hutchinson, Jr./Son 10 Harrison Ave Helena, MT 59601-20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Pages ' cemetery, crematory or other place) ₹ 1 ☐ Burial 25 Cremation 3 ☐ Removal from State **≒** 5 permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, Maryland 02-25-2006 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Rapp Funeral & Cremation Services ma135 8 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclerotic Cardiovascular Disease Physician disease or condition resulting in death) 10 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine death certificate be executed use as the burial-transit Division of Vital Records, P.O. Box 68760. resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No 24a. Was an page 2 certificate has perion 2 No 1 ☐ Yes or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) GROUD 1 ☐ Yes 2 No 1 🗌 Inpatient Certification: To 2 ER/Outpatient 3 DOA Home. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 9 317 23/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert F. Byrne 2333 S Nash St. Arlington VA 22202 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

			1- For State of Maryland /	Department of H Certificate of I	lealth and M Death		iene	05838
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Philip A. HOFFMAN			2. Date of Deat Month Februar	h Day Year	3. Time of Death
	Examin		4a. Facility Name (If not in stitution, give street and number) KESWICK NURSING HOME	BA	LTIMORE If Under 24 Hrs.	9 Date of Birth	4c. County of Deat	N/A
	Funeral Director		5. Social Security Number 218-01-8962 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last bi	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, FEB. 18,	1921	hplace (State or Foreign untry) MD
	Maryland 8-f show	tor		wn or Location				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the 23e or 28	rai Director	10e. Street and Number 3801 CANTERBURY ROAD #1007	10f. Zip Code	21218		0g. Citizen of What Co	USA
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Haalth and Mental Hyglene. Item 27 is marked other then "neturel; or items 23e or 28e-f show other treumetic event, the Medical Everylari mermetic event, the Medical Everylari mermetic event, the Medical Everylari mermetic event.	by Funeral	11. Marital Status 1 □ Never Married 2 M Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No WW I I If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
Maryland 21215-0036	within 72 ho iene. then "netur the Medical.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired PROPRIETOR	during most of work	ng	PRINTING C	·
land 2	should be filed nd Mental Hygir marked other imetic event,	To Be C	17. Father's Name (First, Middle, Last)	HOFFMAN	18. Mother's Name		Maiden Sumame)	THAIMAN
	1 and 2 should Health and Men tem 27 is marke		19a. Informant's Name/Relationship (Type, Print) PHYLLIS HOFFMAN / WIFE 3	b. Mailing Address (Street: 3801 CANTERBU	JRY ROAD	#1007 -	BALTIMORE,	MD 21218
Baltimore,	e = 5		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1	of Disposition (Name of ery, crematory or other place SINAI CEMETER	RY 02/20	6/2006	20c. Location - City or OWINGS M	ILLS, MD
Ball	permit. Pag Department importent: i eny injury c		21. Signature of Funeral Service Licensee		TERSTOWN_	ROAD - P	ON & BROS.	-
	Physician /Medical		resulting in death)	ATE (Ara		or respiratory arre	est,	Interval Between Onset and Death
	Examiner	e.	Due to (or as a consequence Sequentially list conditions, if any, leading to immediate Due to (or as a consequence					
68760 , <	death certificate be executed e atlending physician and of for use as the burial-transit	icai Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence	ə of):				
P.O. Box 68	the death certifical / the attending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	th 3 Ectopic pregnancy 5 Other (specify)	y		23d. Date of del Month	ivery Day Year
Ś	quires that the de n signed by the a uld be detached t	þ	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause giv	ven in Part I.	23e. Did tol	bacco use contribute to es 2 N o 3 ☐ Pr	the cause of death?
Record	The law requires that the vate has been signed by the page 2 should be detache	Completed	anemia 1			24a. Was a autops perform	sy prior to	utopsy findings available completion of cause of
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Outpatient 3 DOA Oth	26. Place of Deat		ence 6 □Other (Spe	cify
of	ing After une	I		. Time of 28c. Injur			ow injury occurred	
Division	or Attenditer deat	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)			28f. Location (St City or Town	treet and Number or Ri n, State)	ural Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical C	29a Certifier To Certifying Physician: To the best of my knowledge	ge, death occurred at the tir and/or investigation, in my c	me, date and place, opinion, death occur	and due to the cred at the time, d	ause(s) and manner as late and place, and due	s stated. e to the cause(s)
)	To the To the Comp	A	29b. Signature and title of certifier Usually Chr M O	29c. Licens	35102	2	19d. Date signed (Mont	24 2006
	12		30. Name and address of person who completed cause of death (Item 23a	(Type, Print) CHAVIES St	very Ba	thmor	e mary 1	Ano
	Sta Regist		(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a Hilam Jon m. D. Sul north 15 and 15	Sperte				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Milton Month 7:08 PM **Physician** Lester /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Poirh Heights Avenue, Apt. 409 Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT. 25,1917 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 M 2 □ F 213-05-8629 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "naturel", or Iteme 23a or 28a-f ehow eny injury or other traumatic event, the Madical Examines man be notified. 1 Yes 2 □ No Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6317 PARK HEIGHTS AVENUE #409 USA 21215 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No WHITE If Yes, Give Year or Dates: Specify. 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES **JEWELRY** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HURWITZ LENA HURWITZ 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA HOWARD / DAUGHTER 6317 PARK HEIGHTS AVENUE #408 - BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State SHAAREI ZION CEMETERY 2/26/2006 4 ☐ Donation 5 ☐ Other (Specify) ROSEDALE, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Corenary artery 30 ×13 **Physician** /Medical 30 x13 **Examiner** 1+ Muragalerasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) □Yes 2□No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 certificate has autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 24 within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifie 2 DO057830 February 25, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bronx, New York 10461 David B. Gittitz 3219 East Trement Averye 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

		•	For State Registrar	State of Mary	•	artment of F			iene _{eg.No.} U ()	05840
	Physici /Medic		Decedent's Name (First, Middle, Last) FLORENCE		HOW	ARD		2. Date of Dea Month Februar	Day	Yeer 3. Time of Death
	Examir	er	4a. Fecility Name (If not institution, give s LEVINDALE HEBREW	HOME		4b. City, Town, o BALTIM(ORE		4c. County of	Death N/A
	Funeral Director		5. Social Security Number 213-12-2668 Usual Residence of Decedent	M 2 7. Age (In	yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Birth (Month, Day) FEB. 10/	1921	9. Birthplace (State or Foreign Country) MD
	ne Maryland 8a-f show ottlied at	ector	10a. State 10b. County N/A		c. City, Town or Lo	IMORE				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygene. itam 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event. The Medical Examinar must be notified at	by Funeral Director	10e. Street and Number 6317 PARK HEIGHTS 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	AVENUE #40 2. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give A Year or Dates:	in U.S. 13.	Vas Decedent of H f Yes, specify Cuba	212. dispanic Originan, Mexican, I			USA - American Indian, White, etc. WHITE
21215-0036	filed within 72 hou Hygiene. othar than "natura ent, he Medical E	Completed b	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual Occup kind of work done DO NOT use retired EEPER	during most o		16b. Kind of Busi	iness/Industry
Maryland	should be fit ind Mental H is markad oth umatic even	To Be	17. Father's Name (First, Middle, Last) JACOB		PAUL	, ,	SAR/	s Name (First, Middle, AH	Maiden Sumame,	TONEY
Baltimore, Man	permit. Pages 1 and 2 sho Department of Health and Important; if itam 27 Is my any injury or othar traum <u>once.</u>		19a. Informant's Name/Relationship (Ty, MILTON L. HOWARD 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	/ HUSBAND 2 amoval from State	6317 Ob. Place of Disponsion of the Computery, crest SHAAREI Z	PARK HE. sition (Name of natory or other plac ION CEME 2. Name and Addre	TERY Of		O - BALT 20c. Location - C ROSEDALI SON & BRO	IMORE, MD 21215 City or Town, State E, MD OS., INC.
8760, <	death certificate be executed Was as the burial-transit A for use as the burial-transit	icai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	insequence of):	105ic		ASCUL OV		Approximate Interval Between Onset and Death
O. Box 6	that the death certifica ed by the attending ph detached for use as tt	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 (\$\frac{1}{2}\$\$\text{No}\$\$ 0 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy	у		23d. Date Mont	of delivery h Day Year
rds, P.	ngi pe	Ď	Part II. Other significant conditions cor	tributing to death but no	ot resulting in the u	nderlying cause giv	ven in Part I.			oute to the cause of death?
al Records,	The ate h page	Completed	Batetes Consestive	Mellitas Heart	failur	7		24a. Was a autop: perfor 1 □ Yes	sy pri med? de	ere autopsy findings available for to completion of cause of sath?
Division of Vital	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page.	Certification; To Be	25. Was case referred to medical examiner? 1	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc. (5	· At home, farm, sti	f 28c. Injur Wor M 1	ner: 4 ☐ Nurs	0	ence 6 Other ow injury occurred treet and Number	
Ω	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	edical Cer	(Check only 2 Medical Examin	sician: To the best of m						
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	(0		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	Print) Roll	ladore	Aro L	HA M	1 21215
	Sta Regist		31. Date filed (Month, Day, Year) FEB 2 8 200	6 3. Registrar's	Signature	elis		NV M	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	

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			For	State of Mar					Mental Hyg	giene	16 6	TEOLI
			1 - State Registrar		(Certifica	ate of	Death	F	Reg. No.	10 (10041
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	/Medio		4a. Facility Name (If not institution, give s		a ic.	4h C	ity Town o	or Location of Deatl	Pelerva	4c. County	of Death	3.30
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1			Baltimore washingt 5. Social Security Number 6. Sex		In yrs. last birth		der 1 Year		_ 8. Date of Birth			
J	Funeral Director			IM XXF	51 Y	B. A			(Month, Day	(, Year)		ce (State or Foreign
- Now			Usual Residence of Decedent						Aug 4	1954	Mary1	and
3	land		10a. State 10b. County	1	Oc. City, Town	or Location					10d	. Inside City Limits
P	Mary	្រុ	Maryland Anne A	runde1	Se	vern						1 ☐ Yes 2 No
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	lten d	Ë	1 Never Married 2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/	Armed Forces?		If Yes, s	pecify Cub	lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	Blac	e - American k, White, etc	
36	rs af	by F	3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 🗆 Yes	2 XNo	Specify:		Specify	: B1a	ck
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Holland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. Item 27 Is marked other then "natural", or items 23a or 28a-f shov other traumatic event, the Madical Examinar must be notilied at		19a. Informant's Name/Relationship (Typ									ode) 21061
	and ealth m 27		Thomna M. Ringgo					th Lane		Glen B	urnıe	e, Md.
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	omoval from State	20b. Place of C	Disposition (A	Vame of	ce)	Date	20c. Location -	City or Town	, State
Ĕ	Pag Pent Int: I		4 Donation 5 Other (Specify)	emoval from State	Memor				7-06	E1krid	ae, N	١d.
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ä	P = 1 0		Janu M	Reese inc.	05/87	WIII	Kees Woot	e & Sons St. Ani	s Mortu	ary, P	A.	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on									pproximate
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.			,	3.	1		In	terval Between nset and Death
	Physician /Medical		disease or condition resulting in death)		morr	hag	ic	Stro	ok e			day
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Records, P.O. Box 68	The law requires that the death certifical ste has been signed by the attending phybage 2 should be detached for use as the	Physician/Med	IF FEMALE:									
õ	th cer endin	Jue /	23b. Was decedent pregnant 23	3c. If yes, outcome of 1 Live birth 2 [3 □Ectopic	DIAGO COOL			23d. Date	of delivery	
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o.	of the de by the a	hys	9 Unknown	9□ Unknown								
<u>رة</u>	es the igned be det	ру Р	Part II. Other significant conditions conf	tributing to death but r	not resulting in t	he underlying	g cause giv	en in Part I.	23e. Did to	acco use contr	ibute to the d	ause of death?
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Division	r Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm	, street, facto	ory, office		28f. Location (St City or Town	reet and Number	r or Rural R	oute Number,
	Hospital or 24 hours afte Funarsi Dir tely filled in	Ce		, sanding, sto. (оросну)				Ony or Your	i, State)		
	ospl hour unar iy fill		29a. Certifier 1 Certifying Physi	cian: To the best of n	ny knowledge, d	death occurre	ed at the tim	ne, date and place,	and due to the ca	ause(s) and mar	ner as state	d.
	ne Ho n 24 ne Fu	Medicai	(Check only 2 Medical Examin	er: On the basis of ex and manner stated	amination and/	or investigation	on, in my o	pinion, death occur	red at the time, da	ate and place, a	nd due to the	e cause(s)
	To the Hospital or Attanding F within 24 hours after death. To the Funaral Director: Atter completely filled in by the funer.	ž	29b. Signature and title of certifier	-100	51,	2	29c. License	e number	2	9d. Date signed	(Month, Day	r, Year)
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	n	1	30. Name and address of person who con	nnleted cause of doct	h (Itam 22a) (T	upa Brieth	· ·	040	/ ^	1 -01	revy	,
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	Sta	te	31. Date filed (Month, Day, Year)	32. Segistrar's	Signature	1000	711	11/11/1				, , , , ,
	Registra		FEB 2 8 200		. K	Breste	P					

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			State of Maryland / Department of Health and N 1- State Registrer Certificate of Death		jiene	06	05842
	Physici		1. Decedent's Name (First, Middle, Last) Jarline Howard	2. Date of Dea Month	Day	Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	HOMENON	4c. County	of Death	7 9 1
			Baltimore Washington Hospital Glen Burnie 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth			andel
	Funeral Director		219-38-2689 1 M 2 F 63 Yrs. Months Days Hours Min.	July 5	Year)	Mary	lace (State or Foreign try) 11and
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	r 28a-f show	ctor	Maryland Anne Arundel Glen Burnie				1 ☐ Yes 2 X No
	death with the Maryland ms 23a or 28a-f show r Tust be nettilled at	al Director	10e. Street and Number 7354 Green Acres Dr. 21060	1	10g. Citizen of V USA	What Coun	try?
2	5 E E	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	ecify Yes or No- Rican, etc.)	14. Rad Blad	e - Americ ck, White,	
5-0036	72 hours after of natural, or Iter dical Exeminer	δ	3 ☐ Widowed 4 🗓 Divorced If Yes, Give Year or Dates:			/: B1a	
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五22	ed with ygiene. ner thai	Com	Elementary/Secondary (0·12) College (1-4or 5+) Custodian		School		
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TA RUNE altimore, Maryland	es 1 and 2 should be of Health and Ment filem 27 is marked in other traumatice.		19a. Informant's Name/Relationship (Type, Print) Gregory Howard (Son) 19b. Mailing Address (Street and Number or Run 7354 Green Acres Dr				
P.E.	or other		20a. Method of Disposition 20b. Place of Disposition (Name of cede) pp prempton (Name of cede) pp p prempton (Name of cede) pp p p p p p p p p p p p p p p p p p	Date	20c. Location -	City or To	wn, State
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rds, P.	v requires thet the been signed by should be detected	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to			e cause of death?
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	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, or my opinion, death occurred and manner stated.	and due to the c red at the time, d	ause(s) and ma late and place,	anner as st and due to	ated. the cause(s)
	To the within 2 To the comple	Ž	29b. Signature and title of certifier 29c. License number	2	29d. Date signe	d (Month, i	Day, Year)
	1		36 Name and address of person who completed cause of death (Item 23g) (Type-Print)_		Moma	70	, rode
_	り		Lyoken Out of ung. 30/ HEAVEN DEWE Gen Durnt	· 1/2	0 7	1061	<i>)</i> .
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State of Maryland / Department of Health and Mental Hygiene (1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** PM February amuel 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner Anne Park Lanc Contor Mrundel tammonds Broklyn If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours Min 1**⊠**M 2□ F 248-0309824 Yrs. Director 3-9-1919 86 Carolina Usual Residence of Decedent with the Maryland 10a State 10h Count 10c. City. Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f showing the Medical Examiner must be notified at 1⊠Yes 2 No Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 Warfield Road 21060 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No **Black** þ Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 8th 0 Truck Driver Textile Co. of Health and Mental Hygie If itam 27 is marked other in other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David Howard ပ Mattie Black 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Norris (Neice) 216 Warfield Rd. Glen Burniem Md. 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of h
Important: if its
eny injury or ot
once. M Burial 2 Cremation 3 Removal from State Arbutus Mem. Park 2/18/06 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reese & Sons Mortuary, West St. Annapolis, Md Zarry. MUC58 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition **Physician** pinentra 1/eus /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy jo in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vascala Disene 10 Yes 20 No 44 Onknown 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy 2 1 1 ☐ Yes 2 2 100 1 Yes funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 JH 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After the Hospital or Attending 1 Natural 5 Pending death. 1 □ Yes 2 □ No investigation 2 Accident thours after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel [1 Priffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title 6 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, Paltimer East an 901 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#19a-b, per Fh, 6852, 2/28/06 IT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 7:36 **ISAACS** FEBRUARY 25 2006 SHIRLEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sinai N/A City Baltimore Hospital Sex Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month Day, Year) NOV.12, 1930 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 2₩F MD 75 214-24-3318 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28e-f show the Madical Exerciner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or USA 3932 SETONHURST ROAD 21208 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify Be Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FOOD & HEALTH MARKET RESEARCHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be find and Mental F BACH WOLBERG ANNMYER 19a Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m SHELLI ISAACS / DAUGHTER other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD CHIZUK AMUNO ARLINGTON 2/27/2006 injury 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acute Myccardial Physician <u>Lufarction</u> disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown failue been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an LIVONIC autopsy 1 🗌 Yes 2/1 No certificate or Attending Physician: illed in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Atatural 5 Pending 1 ☐ Yes 2 ☐ No death investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 25, 2006 RES pupou M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Starrou Sinai m.o. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

2006

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	1 - For State Ragistrar	State of Marylan		tment of F <i>ificate of</i>			giene Reg. No.	106	05845
Physician	1. Decedent's Name (First, Middle, Last)					2. Date of De _Month	Day	Year	3. Time of Death
/Medical	William 4a. Facility Name (If not institution, give s	Johnson, J		4h City Town o	or Location of Deat	Hebru	-	24 2000 County of Deat	
Examiner	C 1 A 2 . 1.	Spital		Bulti				Ltimore	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Bir	th		hplace (State or Foreign
Director	219-28-4877	IM 2□F 72	Yrs.	World Days	Tiodis Willia	12-11-	1933	MD	
and	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loca	ation					10d. Inside City Limits
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ifier death with the Mar ritems 23e or 28e-f s it er must be publica- funeral Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	untry?
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er dea		12. Was DecedenI Ever in U Armed Forces? 1XXYes 2 ☐ No	.S. 13. W	as Decedent of I	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.))- 1	4. Race - Ame Black, White	
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O	20a. Method of Disposition	20b. F	Place of Disposi	tion (Name of atory or other pla	cel Court,	Date		cation - City or	Town, Slate
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Balti Permit. Departm Importa	21. Signature of Funeral Service License	99	22.	Name and Addre	ss of Facility Si	ngleton	Fune	ral Hor	me, PA
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	23a. Part1. Enter the disease, or compli shock, or libert failure. List only or	cations that caused the deat re cause on each line.	h. Do not enter	the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
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7	37 cer 11 Casri	ompleted cause of death (1)	n 222) /Turn D	(101)	0,00	-	-ex	Yver	29, 0006
10	30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type, P C (MO)	ie, m	0,212	29.			
State	31. Dale filed (Month, Day, Year)	32 Registrar's Signa		nt	•				

DHMH 17 Rev 1/2001

ORIGINAL

Haddon Johnson III Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-1205 Unpend item#23a 27 perMF 0853 3/2/06 TT Department of Health and Mental Hygiene AKG 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Haddon Johnson III February 16, 2:50 P M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 347 Cresswell Road Brooklyn Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 25, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**]M 2□ F 57 254 78 4422 Öhio Director Yrs Usual Residence of Decedent Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits wode Baltimore Anne Arundel 1 Tyes 2X No Director Maryland 28a-1 the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Iteme 23a or 2 other count be o 347 Cresswell Road 21225 U.S. death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed other than "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Financing Automobiles years of Health and Mental Hygie Item 27 is marked other rother traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emmy Helen Ivey Haddon Johnson Jr. ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 380 Hammocks Trail Greenacres, Florida 33413 Kimberley Johnson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6 permit. Page Department of Important: if any Injury or once. 2/25/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 22. Name and Address of Facility 23a. Part 1. Enter the disease of dymplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Cist only one cause on each line. 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Afteriosclerotic cardiovascular disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physicien ar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending to for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of leath?
Yes 2 \sum No autopsy Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Che ck only one Hospital: Other: 4 Nursing Home 5 Residence KNOther (Specify) at Scene Certification: To 1 X es 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA : After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1X Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours effer death To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 | Homicide 1_ Certifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 17, 2006

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ted cause of death (Item 23a) (Type, Print)

EB 2 8 2006

nature Apa

111 Penn Street, Baltimore, Maryland 21201

			For Stete Registrer	State of Marylan	•	artment of H tificate of L			giene Reg. No.	06	05847
			1. Decedent's Name (First, Middle, La	st)				2. Date of Dea		V	3. Time of Death
Н	Physicia /Medic		Madison Hollingworth	Kenly, Sr.				February	12, ^{Day} 2006	Year)	8:05 AM M
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death	1	4c. Cour	ity of Death	
			Lorien @ Riverside			Belcamp			Harfor	rd	
	Funeral		Social Security Number 6. S		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h v Year)	9. Birthp	place (State or Foreign
	Director		216-28-6956	XX M 2□ F 75	Yrs.	Working Days	riodis iviii.	Jan. 2, I	931	Maryla	and
	DC >		Usual Residence of Decedent 10a. State 10b. County	10c Cib	, Town or Lo	agtion				- 1.	10d. Inside City Limits
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	er de Itam	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S) n, Mexican, Puert	pecify Yes of No o Rican, etc.)		ace - Americ lack, White,	
36	', or		1 Never Married 2 Married 3 XWidowed 4 Divorced	1) Nes 2 □ No If Yes, Give Year or Dates: 53/61		1□Yes 2ሺ No	Specify:		Spec	eity: Blac	al a
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Maryland 21215-0036	should be t and Mentel I a marked or numatic ave	To B					Hattie Ken	1v			
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Ž	nd 2		Nadine Kenly/ Daught	er	112 Bl	uebill Ct.,	Havre De	Grace. MD	21078		
ē,	f Her item oths		20a. Method of Disposition	20b. P		sition (Name of natory or other place		Date	20c. Location	n - City or To	own, State
Ĕ	Pages nent of int: If it iry or o		1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	THemoval from State	ison Fo		02–21	-06	wings M	[11e M	brelens
Baltimore,	그 된 원 글		21. Signature of Funeral Service Licer			Name and Addres					
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	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Sub to (or as a consequ	aarioa of):					1	
	rcuted nd transl	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
Ó,	e exe ien a urial-	EX	resulting in death) Last	Due to (or as a consequent	uence of):						
8760,	cate be executed physicien and the burial-transit	dical		d						-	
S S		Me	IF FEMALE:	20. 1							**
ô	death certifi e ettending id for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3	Ectopic pregnancy			4	Date of delive Month	ery Day Year
.O. Box	e de the e	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown	eath 5	Other (specify)					,
٥.	The law requires that the death certif ele hes been signed by the ettending page 2 should be detached for use a	by Physician/Me	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause give	on in Part I	23e Did to	nhacco use co	ontribute to t	he cause of death?
Division of Vital Records,	signe d be	b b	renal failure, anemia				AT 11 T W. I.				bably 4 ∭Unknown
Ö	w requir been si should	Completed	real restate, dient								
3ec	e faw hes i	gr		·				24a. Was autop	an 241 osy rmed?	prior to co death?	opsy findings available impletion of cause of
<u> </u>	hysician: The law his certificete hes b I director, page 2 s								2. No	1 Yes	2 □ No
Ë	ilclar certif rector	Be	25. Was case referred to medical examiner?	Hospital:		ot all DOA Othe		ith (Check only o			
ō	Phys this ral di	1	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient 2	ER/Outpatier 28b. Time of	" 30 DOX	4 A Harsing	ome 5 Resident			fy)
L O	Attanding Physician: r death. sctor: After this certifice by the funeral director; g	lo lo	1 XNatural 5 ☐ Pending	(Month, Day Year)	Injury	Work	(? Yes 2 ∐No	280. Describe i	iow injury occ	uneo	
S	l or Attan efter deat Director: I in by the	ca	3 ☐ Suicide 6 ☐ Could not b	e Oga Place of Initial At h	ome farm str			28f. Location /	Street and Nu	mher or Rus	al Route Number,
<u> </u>	or A efter Direct In by	Certification:	4 ☐ Homicide determined	building, etc. (Specif	y)	oot, taddry, office		City or To	wn, State)		
_	spita nours neral filled		29a. Certifier 1 X Certifying Pl	nysicien: To the best of my kno	wledge, deatl	h occurred at the tim	ne, date and place	, and due to the	cause(s) and	manner as s	stated.
	To the Hospital or Attan within 24 hours efter deat To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Execute one)	miner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my or	oinion, death occu	rred at the time,	date and plac	e, and due t	o the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier			29c. License			29d. Date sig		Day, Year)
			0	nnn		D27975	Po	27975)/13/2m	5	
/	6+1)		30. Name and address of person who	completed cause of death (Item	1 23a) (Type,				. <u>/ 13/ 200</u>	,	
1			David W. Mcclure, 615								
	Sta	ite	31. Date filed (Month, Day, Year)	3 Registrar's Signa	ture	1 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			·····		
	Registi	rar	FEB 2 8 20	106 Klasse D	-						

DHMH 17 Rev 1/2001

Registrar

			1100001	State of Mar		/ Denartme			_		gible.	
		1	For State Registrar	Otate of Ivial	ylaria	Certifica			wichtai i iy	Reg. No.	116	05810
			Decedent's Name (First, Middle, Last)	-11	1				2. Date of De	ath	100 to 1	3. Time of Death
	Physici /Medic			Ellen	1	(40/C+	211		Febru	ary 24	1, Zoo	62:35 PM
	Examin		4a. Facility Name (If not institution, give s	treet and number)	C	4b. Cit	y, Town, or	Location of Deat	h		nty of Death	
4	Signature of the state of the s		St. (-lizabeth	Nursin	g Le	nter	150	If Under 24 Hrs			Baltim	
1	Funeral Director		5. Social Security Number 6. Sex 214-01-8690	M 2⊠F	(i h yrs. ias 89	Yrs. Month	er 1 Year s Days	Hours Min.	(Month, Da	ay, Year)	9. Birth	nplace (State or Foreign untry)
	ס		Usual Residence of Decedent						Aug 7,	1910	Mar	yland
	arylan show		10a. State 10b. County	1	10c. City, 7	Town or Location						10d. Inside City Limits
	8a-f	Director	Maryland Howard		El]	licott Ci						1 Yes 2 No
	with t		10e. Street and Number			101. 2	Cip Code	2		10g. Citizen		•
	ns 23	Funeral	8101 Valley Lane	12. Was Decedent Ev	er in U.S.	13. Was Dec	2104 edent of H		Specify Yes or No			States
9	or Ital	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No				ispanic Origin? (S in, Mexican, Puer	to Rican, etc.)		Black, White	
21215-0036	ilied within 72 hours after death with the Maryland Hygiene yther than "naturel", or Itams 23a or 28s-f ehow sint, Ita Medical Examinat must be notified at	Completed by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			2₩ No	Specify:		Spe	icify:	White
<u>5</u>	"natu	lete	15. Decedent's Educ (Specify only highest grade			16a. Decedent's Us (Give kind of v	vork done o	ation during most of wo f)	rking	16b. Kind of	Business/I	Industry
12	withi iene. r than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemak		7		Owr	1 Home	2
פַ	other other	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle			
/lar	Menta Menta Prked	To E	Earl D. Smith					Louis	e V. Em	ler		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Items 23s or 28s-f show any injury or other traumatic event, the Medical Exactinat must be notified at ODGs.		19a. Informant's Name/Relationship (Ty)		_							
	1 and 1ealth em 27 ther t	54	Tina L. Schillinber 20a, Method of Disposition	rg – in lav		8101 Va. be of Disposition (N		Lane, El	licott (nd 21043
Baltimore,	ages nt of the		1 XBurial 2 ☐ Cremation 3 ☐ R	emoval from State	cem	netery, crematory of	other plac			20c. Locatio		
뜶	artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligense	98	Mead	dowridge 1				Elkrid	lge, M	laryland
ä	perm Depa Impo any i) Six ()	han		4107	Wilk	ens Aven	ubard Fi ne Bali	limore	Home,	nc. land 21229
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	ne death.						1111	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ie cado on eagh inte	1)	ment	70					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a			1					1
	Ladininei	_	Sequentially list conditions, if any, leading to immediate	Due to (or as a	W		12					months
	ted	nlne	Cause (Disease or injury	Due to (or as a	consequer	rice or):						
Ć,	ie be executed ysiclan and e burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a	consequer	nce of):						
760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	cai										
89	ntifica ng ph	Med	IF FEMALE:									
P,O. Box	ath ce ttendi or use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1☐Live birth 2	☐ Fetal de	eath 3 Ectopic					Date of deli-	very Day Year
о -	the a	yslc	1 ☐ Yes 2 ⚠No 9 ☐ Unknown	4☐Pregnant at tir 9☐Unknown	me of deat	th 5 Other (specity)				WG/III	Juy Tour
σ.	that t	y Ph	Part II. Other significant conditions con	tributing to death but	not resulti	ng in the underlying	cause give	en in Part I.	23e. Did 1	tobacco use c	ontribute to	the cause of death?
rds	quires n sign lid be	d by	Diahetes v	nellitu	3				1 🗆	Yes 2□No	3 🗆 Pro	obably 4 Unknown
O O	s bee	olete	History of s	itrolce					24a. Was		b. Were au	topsy findings available
æ	The la	Completed							auto perfo	psy ormed? 2 A No	death?	completion of cause of
Vital Records,	Attending Physicien: The law requires that the death certifica rideath. cator: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it by the funeral director.	Bec	25. Was case referred to medical examiner?					26. Place of De	ath (Check only			20,110
<u>\$</u>	Physic this o	P	1 ☐ Yes 2 No	lospital: 1 Inpatient		VOutpatient 3		4/12 Nursing I	Home 5 ☐ Resi			cify)
no	ding I h. After funer	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year)	8b. Time of Injury M	28c. Injun Worl	yat k? Yes 2 □ No	28d. Describe	how injury occ	curred	
Division of	Atten r deat octor: y the	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	y - At hom			100 20,10	28f. Location (Street and Nu	mber or Ru	ıral Route Number,
á	al or a safter of in Direction to	Certification:	4 Homicide determined	building, etc.	(Specify)		,		City or To	wn, State)		
	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Phys	sician: To the best of ner: On the basis of e	my knowle	edge, death occurre	d at the tim	ne, date and place	e, and due to the	cause(s) and	manner as	stated.
	To the P within 24 To the F complete	Medi	2.10,	and manner state	ed.				ar the time,			
	To To		29b. Signature and title of certifier	100/12	20	2	9c. License		r	29d. Date sig		
	1		30. Name and address of person who co	moleted cause of don	ith (Item ?	3a) (Tyne Print)	WS	5-391		emu	wy	27,00
1) '		Mina Vi 3320	Beneu	nA	-venue	, 13	altim	ore , V	Nary	(an	24,2006 d 21227
	Sta		31. Date filed Month, Day, Year)	32. Registrar	s Signatur	le Sant	,				-	
180	Registr	ar	FFR 2 8 7	106 1000	to do	The property of						

		1 - For State Registrar	State of Marylan		ent of Health and I ate of Death	Mental Hygie	.000	15850
1.0	ø.	Decedent's Name (First, Middle, Last)	1	00/11/100		2. Date of Death	NO.	3. Time of Death
Physici		0 1	. 11	•			Day 26 Hook	8:38 AM.
/Medi		4a. Facility Name (If not institution, give			ly, Town, or Location of Death	FIBRURY	4c. County of Death	9.08
Examili	iei . 3	UPPERTHUSAPE	, ,,	1 0	11010		HARFOR	Ω
Funeral		5. Social Security Number 6. Sex	1111-010-21 112		der 1 Year If Under 24 Hrs.		9. Birthpl	ace (State or Foreign
Director		818-38-4PPB 1X	M 2□F 65	Yrs. Month	s Days Hours Min.	Month, Day, Ye	140 MAR	PLAND
р.		Usual Residence of Decedent				1		
anylau	-	10a. State 10b. County		y, Town or Location			10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
88-1-88	cto	MARILAND HARFOI	30		HILL			
Mith th	Director	10e. Street and Number	\	10f	Zip Code	10g.	Citizen of What Coun	try?
ath v	Funeral	2201 BRADVIZL	12. Was Decedent Ever in U	S 40 Wes Da	cedent of Hispanic Origin? (S	anat Van as Na	14. Race - America	a lodico
S p m	, u	11. Marital Status 1 Never Married Married	Armed Forces?	If Yes, s	pecify Cuban, Mexican, Puert	o Rican, etc.)	Black, White,	
336 urs af	by	3 Widowed 4 Divorced	MYes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: \ 174	176
2 hours a sturnit, o	ted	15. Decedent's Edu	cation	16a. Decedent's U			. Kind of Business/Ind	ustry
7 2 E E E	pie	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind of life. DO NO1	work done during most of wor Tuse retired)	rking	- 0	
₩ da wift and with a second s	Completed	12785		6,62 L	FITTER	Co	INIRAL (8)	23010
0836 and 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. Indicate than "natural", or Items 23a or 28a-1 show event, the Modical Examinat must be notified at	Be (17. Father's Name (First, Middle, Last)	3.6		18. Mother's Nam	ne (First, Middle, Main	den Surname)	
	2	HARVIY EOI	NORD KEYES	SR.	A10,V	JORACE .	GOHEER	
	1	19a. Informant's Name/Relationship (Ty	pe, Print)	100% 9	ess (Street and Number or Ru	iral Route Number, Ci	ity or Town, State, Zip	Code) 9:1020
Page a		ZETLIN KENER	205	ASO LA	AUNIEW LA	UE FOREZ	ZHOT 16	RYLAND
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	/	cemetery, crematory o	r other place) MRC	Date A 200	: Location - City or To	wn, State
Baltimor. Baltimor. Beatrie of Pages Department of Moortant: If the pages on injury or of page.		4 □ Donation 5 □ Other (Specify)		THIS! IZ	ropial ac	oop E	The state of the s	RYLAND
Baltimo permit. Page Department of Important: Il mportant: Il eny injury or one.		21. Signature of Funeral Service License	96	EVAN	and Address of Facility	YEST - BET	and the second second	21050
, 0	-	23a. Part 1. Enter the disease, or comol	cations that caused the deat		WHORT DIZIV		HITT I INC	Approximate
		shock, or heart failure. List only or Immediate Cause (Final	to cause on each line.					Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq		CARDIOVAS	CULAR L)(5EAX	
Examiner		AND CONTRACTOR OF STREET	200 10 (0) 23 2 00/1300	(adii 00 01).				
10	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):				
# 0147 8760, c.	Examiner	that initiated events						
50, sien a urrat-		resulting in death) Last	Due to (or as a conseq	uence of):				
# 0 8760 cate be e	dical		d					
Bdx 61 eath certific	/Me	IF FEMALE:	3c. If yes, outcome of pregna	2000	_			
BB	lan	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d	J death 3 □Ectopic			23d. Date of delive Month	ry Day Year
P.O. that the de by the detached	lyslo	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	30000	Specify/			
	by Physician/Me	Part II. Other significant conditions con	ntributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
ords, requires						1 🗆 Yes	2 No 3 Prob	ably 4 Onknown
ecord aw requir	Set					24a. Was an	24b. Were autor	osy findings available inpletion of cause of
I Re	Completed					autopsy performed 1 Yes 2	death?	
	(a)	25. Was case referred to medical			26. Place of Dea	ath Check only one)	10 103	20,10
of Vital Of vital Physician:	To B	examiner?	lospital: 1 Inpatient 2 7	ER/Outpatient 3	DOA Other: 4 Nursing H	lome 5 Residence	e 6 Other (Specify	•)
S j Canada Vita Sing Physician: After this certific funeral director,		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how i		
// S j	cati	2 Accident investigation 3 Suicide 6 Could not be		М	1 Yes 2 No			
Division Attended	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fact fy)	ory, office	28f. Location (Stree City or Town, S	t and Number or Rura state)	Route Number,
Hospital Hospital Hospital Hospital Hospital		29a Certifier 1 Certifiving Phys	sician: To the best of my kno	awled to death edition	of at the change of all case if all and	and due to the owner		and W
Hos 24 hd Fun	edical	(Check only 2 Medical Examinate)	ner: On the basis of examina and manner stated.	ition and/or investigati	on, in my opinion, death occu	irred at the time, date	and place, and due to	the cause(s)
To the Hospital within 24 hours a To the Funeral It completely filled	Me	29b. Signature and title of certifier	1 0		29c. License number	29d.	Date signed (Month,	Day, Year)
		► IMA	Shyanbar	MD	DASUZT	FER	BRUARY 2	6,2006
16		30. Name and address of person who co		n 23a) (Type, Print)	DX5027 E BEL AIR		BRUARY I 1014	
		VIJAY M. ABY YAN	KAR 2 NOR	7	t BEL AIR	MD &	1014	
St. Regist	ate	31. Date filed (Month, Day, Year) FFR 2, 8, 2006	32. Registrar's Sign	TUTO TOTAL				

		•	For State Registrar	State of Maryland	d / Depa	rtmer	nt of H			ental Hygi	ene)6 (15851	
			Hegistrar Decedent's Name (First, Middle, Las	t)	001	incai	COIL	Jean	T	2. Date of Deat	ig. ⁽ No.)	-	3. Time of Death	_
П	Physicia		Edwin L. Kelly							Heburan	Day 24	Year 2006	1	1
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City	Town, or	Location of	Death	TEOCIEST	1	ity of Death	AIIA	_
	Examin	e.	Sinai Hospital		TR.			WEL	-01	,			V/2+	
	Funeral Director		5. Social Security Number 6. Se				r 1 Year	If Under 2 Hours		8. Date of Birth (Month, Day, 11-26	Year) -23	Cour	lace (State or Foreig try) y la <u>nd</u>	n
	p ,		Usual Residence of Decedent	100 City	, Town or Loc	- 41							0d. Inside City Limits	_
	anyla shov	_	10a. State 10b. County										od, inside City Limits 1 XYes 2 ☐ No	
	788-f	ecto	MD n/a	a B	altim		. 0. 1.			14	0.00	(11111111111111111111111111111111111111		
	a or	급	2501 Violet Ave	nuo Ant 91	ON		p Code 1215			"	US2	f What Cour	iity ?	
	eafh	erai	11. Marital Status	12. Was Decedent Ever in U.S				snanic Orig	in? (Snec	ify Yes or No-		ace - Americ	an Indian	
	fer d	Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💢 No				n, Mexican,	Puerto F	cify Yes or No- lican, etc.)	В	lack, White,	etc.	
03	urs a		3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	Yes	2 X №	Specify:			Spec	ity: Afr	ican- rican	
<u> </u>	filed within 72 hours after death with the Maryland Hygiene. other than "naturel; or Items 23a or 28e-f show ent, I'm Medical Exactine from the notified at	Completed by	15. Decedent's Ed (Specify only highest grad		16a. Deced	ent's Usu	ial Occupa	ation	of workin		16b. Kind of	Business/Inc		_
2	ithin ie.	npie	Elementary/Secondary (0-12)	College (1-4or 5+)			se retired	luring most)	Or WORKIII	9				
2	ygien ygien t, l	Ö	10th		Tai	lor					-		eaners	_
בַ	fal H d oth	Be	17. Father's Name (First, Middle, Last)					18. Mother	's Name	(First, Middle, N	faiden Suma	ame)		
<u>\frac{3}{3}</u>	should be nd Menfal n marked umetic ev	P	Leon Kelly					Jose	ephi	ne Fie Route Number,	lds			
Maryland 21215-0036	12 sh h and 7 Is n treun	1 3	19a. Informant's Name/Relationship (7											
e,	s 1 and 2 should be filed within 72 hours after death with the Marylar if health and Mental tygiene if them 23a or 28e-f show item 27 is marked other than "naturel", or Items 23a or 28e-f show other treumetic event, I'm McJical Exactinar man be notified at		Nancy L. Lewis, 20a. Method of Disposition		ace of Dispos			ce Di				dalls n - City or To	21133 town, MD	_
٥	Pages nent of int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	metery, crem	atory or	other place	1						
Baltimore,	rtme rtent njury		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licenters)	Arb	utus	Mem	. Pa	rk	3-2-	06 A	rbuti	18, M	lto.Co.	
Ba	permif. Pages Department of Importent: If it any injury or o		21. Signatura of Futteral Service Licen	11/1/		. Name a	na Addres	s of Facility	Wyl	ie F/H	PA o	of Ba	lto.Co.	
			23a art i. Enter the disease, or comp shock, or heart failure. List only	Dications that caused the death	Do not ente	OO]	ibe	rty I	Rd .	Randal	lstor	√n, M	D 21133 Approximate	-
b	-		shock, or heart failure. List only of Immediate Cause (Final							roopa.o., ao			Interval Between Onsat and Death	
	Pnysician /Medical		disease or condition resulting in death)	a Cerebrova		I 1	tecie	tent					Day	
	Examiner			Due to (or as a consequ	ence or):									
		ē	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	b. — Due to (or as a consequ	ence of):									-
	d d anslf	Examiner	Cause (Disease or injury that initiated events	C										
ó	fe be executed ysicien and te burial-transif		resulting in death) Last	Due to (or as a consequ	ence of):									
3760,	afe be executed hysicien and he burial-transif	icai		d										
39	ntifica ing ph a as fl	Physician/Med	IF FEMALE:											
Вох	leath certific affending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1☐Live birth 2☐Fetal	death 3		pregnancy					Date of delive	ery Day Year	
0	of the dea by the a tached fo	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	ath 5	Other (s	pecify)					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Duy Tour	
P.	The law requires thet the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Ph	Part II. Other significant conditions or	ontributing to death but not resu	Iting in the un	derlying	causa dive	en in Part I.		23e. Did tob	acco use co	ntribute to th	ne cause of death?	
Records,	uires fhef signed b d be deta	d by			•	, ,	3			1 □ Ye	s 2□No	3 🗆 Prob	ably 4 Unknown	1
200	w require been signature	Completed								24a. Was ar	241	Ware auto	psy findings available	
Re	The lav	mp								autops	/	prior to con death?	mpletion of cause of	
a	iclen: Th certificate rector, pag		25. Was case referred to medical					26 Diago	of Dooth	1 ☐ Yes 2 (Check only one	MO I	1 🗌 Yes	2 No	_
>	Physiclen: r this certifica ral director, p	To Be	examiner?	Hospital:	ER/Outpatien	t 3□ D	OA Cthe	an .		e 5 ☐ Reside		ther (Specif	v1	_
o	g Phy er fhis		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work			8d. Describe ho			//	_
Ö	Attending Property of death.	atio	1 ■ Natural 5 ☐ Pending 2 ☐ Accident investigation		injury	М		Yes 2 N	40				•	
Division of Vital	f or Attencater deaff Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, stre	et, facto	ry, office		2	8f. Location (Str City or Town		mber or Rura	l Route Number,	
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	1		30. Name and address of person who	completed cause of death //tom	23a) /Tune 1		KC)	-00		1	Ltur	riy d	4, 2004	>
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Funeral Director Funeral Director 5. Social Security Number 6. Sex 1½ M 2 F 80 yrs. If Under 1 Year Months Days 1219-12-8052 1½ M 2 F 80 yrs. Months Days 102	r Location of Death CE If Under 24 Hrs. Hours Min. Jan 24 Hrs. Hours Min. Jan 24 Hrs. Ja	AC. County of De n / a of Birth 9. B M 10g. Citizen of What (USA) 14. Race - Ar Black, WI	oath Sirthplace (State or Foreign Cart 1 and 10d. Inside City Limits 1 \(\subseteq Yes 2 \subseteq No \) Country?
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Director 219-12-8052 Usual Residence of Decedent 10a. State 10b. County Md. 10c. City, Town or Location Md. 10c. Street and Number 604 South Lakewood Avenue 10b. Street and Number 604 South Lakewood Avenue 11. Marital Status 1 Never Married 1 Neve	Hours Min. Jahn 2 4 ispanic Origin? (Specify Yes of sum, Mexican, Puerto Rican, etc.) Specify:	10g. Citizen of What (USA) 14. Race - Ar Black, WI	10d. Inside City Limits 1 Lyes 2 No Country?
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Joseph O. Layne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street	18. Mother's Name (First, Mi Caroline B		
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street 1723 Westor	Avenue Par Date 2/28/06	·	21234-3721 or Town, State
20a. Method of Disposition 1	et Street B	owski Fune	ral Home,PA
Examiner Sequentially list conditions, flam, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	g, such as cardiac or respirate		Approximate Interval Between Onset and Death
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 1		23d. Date of d Month	lelivery Day Year
		Did tobacco use contribute	to the cause of death? Probably 4 □Unknown
i: The law requirement is the law requirement is page 2 should be completed.		autopsy prior to performed? death?	
3 Suicide 3 Suicide 4 Homicide	A Nursing Home 5 1 28d. Description (28d. Description (28d. Description (28d. Description (28d. Cocard)) (28d. Cocard)	SUBJECT FELL, BROKE H	
The state of Injury - At home, farm, street, factory, office by the state of the st	ne, date and place, and due to	the cause(s) and manner	BA LTITLORE, HD as stated, ue to the cause(s)
	·M.E.	29d. Date signed (Mod FEBRUARY 25	_
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RNA O HD 111 PENN State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	STREET BALTIM	ORE MARYLAND	21201

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Raymond Clyde Little 2006 FEB 2:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) OCT 15, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F Months Director 166-01-2087 Yrs 91 1914 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "naturel", or iteme 23e or 28a-f ehow the Medical Exeminer must be notified at **Funeral Director** 1 ☐ Yes 2 ▼No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3152 Gracefield Road, Apt. 114 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tool & Die Maker Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be fi Health and Mental H Raymond Α. Little ည Caroline Martz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health item 27 114 Mary land 20904 Location - City of Town, State Helen M. 3152 Gracefield Rd., Little, wife Apt. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location Pages nent of P 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 02/27/06 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. Leon 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in daath) Onset and Death Physician Pneumonia Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the ettending I IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Dav Year signed by the el 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should peeu Cellulitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Skin Ulcer this certificate 2 No 1 Yes 1 ☐ Yes 2 1 No : After this certifica tuneral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter or To the Funeral Direct completely filled in by 4 Homicide ō 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0024035 February 26, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road Eugenio Machado, M.D. Silver Spring, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar FEB 2 8 2006

			_ State	d / Department of Health and Mer Certificate of Death	1	CUBB HOODE
	100		Registrar 1. Decedent's Name (First, Middle, Last)	2.	Reg. No	3. Time of Death
	Physici /Medic		Mary Lapachinsky	16	Druary.	25,2006 8:10P M
	Examin	er	4a. Facility Name (If not institution, give street and number) Mary (and leneral FOS);	tal Baltimore (it V		4c. County of Death
150	Funeral Director		218-18-3423 1 M 2 DXF 89	As t birthday) If Under 1 Year If Under 24 Hrs. A. Months Days Hours Min.	Date of Birth (Month, Day, Yea eb 8, 19	g. Birthplace (State or Foreign Country) Pennsylvania
-	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or Location		10d. Inside City Limits
	death with the Maryland me 23a or 28a-f show must be toulfied at	tor	Maryland n/a Ba	ltimore		1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number	10f. Zip Code		Citizen of What Country?
	e 23e		825 Hollins Street	21201		nited States
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Menial Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23e or 28e-f show any injury or other traumatic event, If a Medical Exant are must be notified at 2008.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【文Divorced 12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2 № No Specify:	an, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
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y la	should bud Ment	2	Joseph Melcavage	Pauline A		
Mar	alth and alth and alth and alth and alth and alth are are are are traum		19a. Informant's Name/Relationship (Type, Print) Rosemarie Homberg / Daughter	19b. Mailing Address (Street and Number or Rural Ro 825 Hollins Street, Bal		
ore,	of Herm		20a. Method of Disposition 20b. P	lace of Disposition (Name of Date emetery, crematory or other place)	20c.	Location - City or Town, State
Q.E	L. Pag trrent tent: I		4 Donation 5 □ Other (Specify) Pag	rkwood Cemetery 3/2/06		ltimore, Maryland
Bal	permit Depart Import any in		21. Signature of Funeral Service Liceniee	22. Name and Address of Facility Hubbi		
	- S &		23a. Part1. Enter the disease, or complications that caused the deat	*		Approximate Interval Between
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9	/Medical Examiner		resulting in death) Que to (or as a conseq	uence of):	J	
	130	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	uence of):		
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corc	w requ	letec			24a. Was an	24b. Were autopsy findings available
I Re	The lavele has	Completed			autopsy performed 1 Yes 2	prior to completion of cause of death?
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of	Phys r this ral dir	٦.	Tes 25 No Terinpatient 2		5 Residence	e 6 Other (Specify)
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	107		> Brodutchera	1111) 8952	14 tol	bruary 25, 2006
	10.		30. Name and address of person who completed cause of death (Iter Naria Borogatcheva, M	D C/o Marylana GE	neral	Hospital
2	Sta Regist		31. Date filed (Month, Day, Year) 32 Registrar's Signal FEB 2 8 2006	A Localis		<u> </u>

Carol Louise Lesniewski Mornin Louise Lesniewski				Amend item#4c, pe 1 - For State Registrar	State of Mary		artmen rtificat				Reg. No.	106	0585	5	
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late Chapterfield MD 9103 Finish C. D. Balting 21237	1	1		30 Name and address of person who or	ome ex- cause of dear	th (Item 23a) (Type	Print)	na l	1. 6	Care	, Z	Let	1,000		
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			FOI	eartment of Health and Mertificate of Death		iene . No. 0 0 6	05856		
I	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Marjorie S. Ma	axcy	2. Date of Death Month FEB	26, 2006	3. Time of Death 6:45 P M		
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
		•	Glen Meadows Health Care Center	Glen Arm		Baltim	ore		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday $477-16-0890$ $1 \square$ M $2 \mathbf{X}$ F 82 Yrs.	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, JAN 15,	Year) 9. Birth Cou 1924 Mini	place (State or Foreign Intry) NESOTA		
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits		
	Aaryli sho	ŏ	MD Baltimore	Glen Arm			1 ☐ Yes 2 🏋 No		
	28e-1	ect	10e. Street and Number	10f. Zip Code	10	og. Citizen of What Cou	intry?		
	with 3e or	Funeral Director	11630 Glen Arm Road, U-15	21057		USA			
	ns 2%	era		. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	14. Race - American Indian,				
Maryland 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artenent of Health and Mental Hygiene. Critent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show injury or other treumatic event, the Medical Examina mutil to notified at a night or other treumatic event, the Medical Examina mutil to notified at 9.	by Fun	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto I 1☐ Yes 2【XNo Specify:	Rican, etc.)	Black, White Specify:	, etc. ite		
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pul	be fill d oth	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Name					
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ė,	is 1 and 2 of Health a item 27 is other tree		Frederic R. Maxcy, husband 11630 20a. Method of Disposition 20b. Place of Disp	OGLen Arm Rd., U-1 position (Name of paratory or other place)		ALIII, MD Z			
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Baltimore,	permit. Page Department of Importent: If any injury or once.			22. Name and Address of Facility Cre					
B	Deporting any r		leon E. Man Me	299 Frederic					
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between		
a	Physician		Immediate Cause (Final disease or condition CHRO NIC	RENAL FI	AILUI	262	Onset and Death		
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687	tificate ng phys as the	edic	d,						
Box	eath certif attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of deliv	1		
	death	sicia	1 Pregnant at time of death 5	Other (specify)		Month	Day Year		
P.0	res that the de signed by the a be detached f	Phy	9 Unknown	de la lace de la Companya de Port I	00a Did tab	ann una nantributa ta t	the square of death?		
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900	e law requ has been je 2 shouli	piet	HAPOTHYRODISM HYPER	ZTENSION	24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of		
ä	The late happen	mo		ELANE	perform	ed? death?			
ita	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death					
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n o	fter fter	on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury	Work?	28d. Describe how	w injury occurred			
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Division	or A	Certification:	4 Homicide determined 28e. Place of Injury - At home, larm, s building, etc. (Specify)	freet, factory, office	City or Town,		ar Moute Number,		
	spital ours neral filled		29a. Certifier 15 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, a	and due to the car	use(s) and manner as s	stated.		
Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the care and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye									
	15		30. Name and address of person who completed cause of that (Item 23a) (Type RAM ANA NOPACAN MU	y D 51226 CINC CROSS NO ADS	#159	BALTIMOR	€ 21228		
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		1 - State Registrar	of Maryland	/ Department of F Certificate of			i. No. 006	05857
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/Medic		Willian	February	25, 2006 4c. County of Death	1:48 P ^M			
Examin Funeral Director	er	4a. Facility Name (If not institution, give street and results of the	7. Age (In yrs. las	Timo	n Location of Death Dnium If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	Balt (ear) Balt Ocui	imore place (State or Foreign pland
pug *		Usual Residence of Decedent 10a, State 10b, County	10c, City, 1	Town or Location				IOd. Inside City Limits
Maryle f abo	or				ltimore			1 XYes 2 No
r 288	Directo	Maryland N/A 10e. Street and Number		10f. Zip Code	er crinor c	10g	g. Citizen of What Cou	ntry?
15 with	ai D	2626 Lehman Street			21223		USA	
partition of the standard of the same of the many of the many of the many of the same of the standard many of the same of the	Funeral	1 Never Married 2 Married 1 Ye.	ecedent Ever in U.S. Forces? 2 (XNo		an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	etc.
ours a	1 by	3 ☐ Widowed 4 ☑ Divorced Year or	ilV0	1 ☐ Yes 2 XNo	Specify:		Specify: Wh	ite ————————
72 h	Completed	15. Decedent's Education (Specify only highest grade complete		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of worki	ng 16	6b. Kind of Business/In	dustry
within than	duc	Elementary/Secondary (0-12) College	(1-4or 5+)	Maintenance	•		Electr	onice
Hygin chart,	Be Co	17. Father's Name (First, Middle, Last)		namicenance	18. Mother's Name	(First, Middle, Ma		JIICS
Id be Mental Mental rked tic ev	To B	William L. Mathers			Char	lotte R.	Imhoff	
and h		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street	and Number or Rura	l Route Number, (City or Town, State, Zip	Code)
and and markh		William L. Mathers, II		1501 Alconbur		ssex, MD		
ges 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro	m State cem	ce of Disposition (Name of netery, crematory or other place	ce)		c. Location - City or To	
mit. Pages partment of portant: If it or y Injury or c	0	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licers e	Metr	co Crematory,		7/06	Baltimore	
Dermi Departiment of the post		21. Signature of Fungial Service Licenside	lik				ociety of Dore, MD 21:	
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Physician /Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tary, leading to immediate cause. Enter Underlying	ER OF THE o (or as a consequent	nce of):				Onset and Death
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OI VICA Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:		P/Outpatient 3ET DOA Off	26. Place of Death			
Attending Physic death. ector: After this by the funeral di	tion: To	27. Manner of Death 28a. Da		8b. Time of Injury Wor	4 Nursing Flor	me 5∐ Residen 28d. Describe how	ce 6 **Other (Special injury occurred	W HOSPICE
in the second	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Pla	ce of Injury - At home Iding, etc. (Specify)	e, farm, street, factory, office	-	28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
To the Hospital within 24 hours a To the Funerel completely filled	edicai		he best of my knowle basis of examination anner stated.	edge, death occurred at the tin n and/or investigation, in my o	me, date and place, a pinion, death occurre	and due to the cau ed at the time, date	se(s) and manner as s e and place, and due t	tated. o the cause(s)
With To 1	×	29b. Signature and Affe of certifier		29c. Licens	43725	290	d. Date signed (Month,	
3		30. Name and address of person who completed ca			T-1/03-7-	100 01000		
Sta	ato.		O DULANEY Registrar's Signatur		CIMONIUM,	MD 21093		
Registi		FEB 2 8 2006	Classes L	& foods				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#20c,perFH, \$52,2/28/06 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month McElveen 17 2006 8:50pmM Nathan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Ft. Washington Ft. Washington Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12–23–53 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 12 M 2□ F Yrs. S.C. Director 52 249-08-4633 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or items 23e or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Waldorf Md. Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20602 1115 Harbor Road Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Walter Reed Army Hosp. <u>Custodian</u> 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fit tment of Health and Mental H tant: If item 27 is marked ott Flossie Frierson McElveen Nathan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) New Carrollton, Md. 20784 6009 85th Avenue, Lara Collier Sister 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ö Sansbury Cemetery 2-27-06 Department Important: I eny injury o Timmonsville, SC 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 Brund Mille March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lung /Medical Due to (or as a consequence of): Examiner Brunchiolit Obliterans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) reural or Attending Physician: The law requires that the death certificate be executed o (or as a consequence of) O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 4□Pregnant at time of death 5 Dther (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ivision of Vital Records, Yes 2 No 3 Probably 4 Unknown Cardianyopathy 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 → Appatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D41182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9400 Livingsten Rd FT-WASHINGOW, MO Anderson MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 8 Registrar

			For State Registrar	State of Ma	aryland / I		tment of H		d Mental	Hygiene	11111	05859
	Physici		1. Decedent's Name (First, Middle, Havold Millo						2. Date Mont	of Death	ay Year	3. Time of Death 20:35 PM
	/Medio Examir		4a. Facility Name (If not institution, Wilversity of Mary	give street and number)	u Cente		4b. City, Town, or Baltim			40	County of Death	
	Funeral Director		5. Social Security Number 229–48–9777	6. Sex 7. Ago 1 X M 2 □ F	e (In yrs. last bii		If Under 1 Year Months Days	If Under 24 H Hours Mi	in. (Mon	of Birth th, Day, Year,) Co	nplace (State or Foreign untry) Va.
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	vn or Loca	ation					10d. Inside City Limits
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	th the or 28e	Olrec	10e. Street and Number		 		10f. Zip Code			10g. Ci	itizen of What Co	untry?
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920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Importent: If item 27 ie marked other than "naturel", or Items 23a or 28e-1 show eny injury or other traumatic event, the Modical Examinal must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:		lf Y	as Decedent of His Yes, specify Cubar Tyes 27 No				14. Race - Ame Black, White Specify: B	
2-0	72 hounature	eted	15. Decedent' (Specify onfy highest		16a	I. Decede	nt's Usual Occupa	ition	vorking	16b. F	Kind of Business/	
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lary	2 shou and N ie mai		19a. Informant's Name/Relationsh	ip (Type, Print)	198	b. Mailing	Address (Street a	nd Number or I	Rural Route I	Vumber, City	or Town, State, Z	Tip Code)
	1 and 1ealth nm 27 ther tr		Mary L. Blanton 20a. Method of Disposition	n Sister		29	16 Auche	ntoroly	Terr.	, Balt	inore, M	ld. 21217
nor	ages 1 int of H t: if ite y or ot		1 Burial 2 Cremation		cemete	ery, crema	nt Cem.		-27-06		ocation - City or :	
Baltimore,	permit. P Departme Importen eny injuri once.		4 Donation 5 Other (Sp. 21. Signature of Funeral Service L	icensee	GLEE	22. 1	Name and Address	s of Facility		Balti	more, Mo	3. 21202
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		Medic	15 55 to 15	0.								L
.O. Box	that the death certifi ed by the attending detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		ctopic pregnancy Other (specify)			-	23d. Date of deli Month	very Day Year
s, D	w requires that the been signed by th should be detache		Part II. Other significant condition	ns contributing to death bu	ut not resulting i	in the und	lerlying cause give	n in Part I.	23e.	Did tobacco		the cause of death?
Vital Record	The law ete has b page 2 si	Completed							24a.	Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
Vita	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:			2C DOA Othe	26. Place of D				
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Division	in Direction	Certification:	3 Suicide 6 Could no 4 Homicide determine		ury - At home, fa c. (Specify)	arm, stree	et, factory, office		28f. Loca City	tion (Street a) or Town, State	nd Number or Ru e)	ral Roule Number,
	he Hospital in 24 hours a he Funeral I pletely filled	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of xeminer: On the basis of and manner sta	examination ar	e, death o	occurred at the time stigation, in my op	e, date and placi inion, death oc	ce, and due t curred at the	o the cause(s time, date an	s) and manner as d place, and due	stated. to the cause(s)
	To the I	Σ	29b. Signature and title of certifier-	-			29c. License				ate signed (Month	
•	2		. \	tho completed cause of de	eath (Item 23a)	(Type, Pr	rint)	5/42		Hebv	uans o	MD 2170
(Sta		31. Date filed (Month, Day, Year)	· EF	MD ar's Signature	16	5 GRE	EENE	5,7	BALT	1MORE	WD 5150
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			For State Registrer	State	of Marylan		artment of h				ene	06	05860
			1. Decedent's Name (First, Middle, Last	, ~					1	2. Date of Death Month	Dav	Year	3. Time of Death
	Physicia /Medic		SALLY AND	("):	RABIL	2]	February		2006	10:15p ^M
	Examin		4a. Facility Name (If not institution, give	street and n	umber)		4b. City, Town, o	or Location	of Death		4c. Count	y of Death	
			Greater Baltimo	re Med	dical Cer	nter	Towson				Balt	imore	
	Funeral		Social Security Number 6. Se		7. Age (In yrs. I	last birthday)	If Under 1 Year Months Days	If Unde Hours	r 24 Hrs.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign
	Director		919 10 8419	⊒м <i>2</i> 5 00 г	OP	Yrs.	WOMI'S Day's	riodis		1 P. MAI	dif	NEW	
	P .	-	Usual Residence of Decedent		10- Cit	. Town and							
	anyla ehov	_	10a. State 10b. County		10c. City	y, Town or Lo	4						10d. Inside City Limits 1 ☐ Yes 21 No
	Ba-1	cto	1111/11/10	10(65	1	-ARUZ	-						
	death with the Maryland me 23a or 28a-f ehow r. must be notified at	Director	10e. Street and Number	\bigcirc			10f. Zip Code			10	g. Citizen of	What Cou	ntry?
	ath w	<u>a</u>	2902 LUB HIL	7150	<u>40</u>		313	34			V.	1-1.2	•
5	er de	une	11. Marital Status	Armed F	cedent Ever in U. orces?	S. 13.	Was Decedent of I If Yes, specify Cub	dispanic O an, Mexica	rigin? (Spec an, Puerto R	ify Yes or No- lican, etc.)	14. Ra Bla	ce - Americack, White,	can Indian, etc.
<u></u> 9	ours after death with the Marylan el', or iteme 23a or 28a-f ehow Examiner must be notified at	Ϋ́	1 Never Married 2 Married	If Yes, G			1 □ Yes 27 No	Specify	r:		Speci	b:1 11	13-
28	72 hours naturel', dical Exe	Completed by Funeral	3XWidowed 4 □ Divorced	Year or	Dates:	16a Dans	deetle Union One			14	0b 16: 4 -4.1	MY	3/1/
∧) ₩	d within 72 ho jiene. r then "natur ine Madical	lete	15. Decedent's Edu (Specify only highest grad		1)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during mo	st of workin	g 1	6b. Kind of I	susiness/in	dustry
2	withi ene.	Ĕ	Elementary/Secondary (0-12)	College	(1-4or 5+)	1	EENT	-,		(1025	C. E	272
28	titled Hygi other	S	17. Father's Name (First, Middle, Last)			3	02100	18. Moth	ner's Name	(First, Middle, M.	aiden Suma		1 12
an	Mental Mental arked o	Be c	0.000	000	ALAC			Ω.	1- 10	~ · · · · ·	3001	100	~1~
Marylan	ges 1 and 2 should be titled t of Health and Mental Hyg If item 27 ie marked othe or other treumalic event,	၉	19a. Informant's Name/Relationship (T		2 LT 7.14	19b. Mailir	ng Address (Street	and Numb	per or Rural	Route Number	City or Town	State Zic	Code) 21050
Z B	d 2 s th an treu treu		Martina RM	6, 50	\wedge	03/1	OLLON	100	2010	T-0:57	11:11	000	MOOD
(e)	s 1 and it Health item 27 other tr		20a. Method of Disposition	1 127	20b. P	lace of Dispo	sition (Name of		MARE	ite C 2	Oc. Location	City or To	own, State
M Baltimore,	Pages Jent of I Int: If Ite		TE Burial 2 Cremation 3 1		n State		natory or other pla	Ce)		1 1/	Jake,	C	Jacoba a
뉼		- 1	4 □ Donation 5 □ Other (Specify) 21. Signal 1-3 □ Funer □ Service Licens		1110	if drawn in the	Name and Addre	PAR I	30	0.5	WW	1 2661	INVALAND
Ba	Depertit Depertit Imports eny inja		1 60 H 3	7\		٤	Name and Addre	LEADE	SEL	EWOUR	20010	201-	Marian
			23a. Part1. Enter the disease, or comp	licati s t	caused the death		ar the mode of day			respiratory arres	HIKK	1112	Approximate
			shock, or heart failure. List only of Immediate Cause (Final	ne se on	each line.		4.4		0 0410140 01	roopiiatory arroc			Interval Between Onset and Death
	Physician /Medical	i	disease or condition resulting in death)	a	ardio	neson	athe						
	Examiner			Due to	o (or as a consequ	uence(of): V	· ()					
- 8	100	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	our s a consequ	uence of):	1					-	
V	ted nsit	를	Cause (Disease or mility		y.								
	xecu al-tra	Examiner	that initiated events resulting in death) Last	Due to	o (or as a consequ	uence of):	· · · · · · · · · · · · · · · · · · ·						
8760,	icate be executed physicien and s the burial-transit	dicai E		4									
687	ficate phy:			u									
	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna						23d. D	ate of delive	erv
Вох	atter I for u	clar	in the past 12 months?		birth 2 Fetal		Ectopic pregnanc Other (specify)	у			4	onth	Day Year
P.O.	that the de led by the a detached t	ıysı	1 □ Yes 2 No 9 □ Unknown	9□ Unk	nown		(4, 5, 7, 2						
σ.	The law requires that the death certifi ste has been signed by the attending page 2 should be detached for use as	Į.	Part II. Other significant conditions co	ntributing to	death but not resu	ulting in the u	nderlying cause gr	ven in Part	L.	23e. Did toba	cco use cor	ntribute to t	he cause of death?
Division of Vital Records,	uires n sign	d by	atrene free	Mat	n'ca					1 🗆 Yes	2 □ No	3 Prob	oably 4 Unknown
<u> </u>	w requir been s should	Completed	Allowaged Der	nouh	111					24a. Was an	24b.	Were auto	opsy findings available
Be	The law sete has page 2:	Ĕ	Hararoccu ox	141		,				autopsy	ed2	prior to co death?	impletion of cause of
<u>a</u>	ician: Th certificete rector, pag	ပိ	25. Was case referred to medical					OC Dies	a of Dooth	Check only one	No	1 🗆 Yes	2 No
Ē	Physician: this certificated director, i	0 0	examiner?	Hospital:	Unpatient 2	ER/Outpatier	nt 3 DOA Ot	100		e 5 Residen		has (Canad	4.3
o to	Phys arthis araldi	$\vdash \downarrow$	27. Manny r of Death	28a. Date	e of Injury	28b. Time of	28c. Inju	ry at		Bd. Describe how			y/
o	th. Afte	흝	1	(Mo	nth, Day Year)	Injury	W₀ M 1□	rk?]Yes 2.[]No				
<u> S</u>	Attending it death. ector: Attel by the fune	fica	3 ☐ Suicide 6 ☐ Could not be				eet, lactory, office		21			ber or Rura	al Route Number.
á	alor afte Dire	Certification;	4 Homicide	buil	ding, etc. (Specify	")				City or Town,	State)		
	Hospital 14 hours a Funeral tely filled		29a. Certifier 1 Certifying Phy	sicien: To th	ne best of my know	wiedge, deati	occurred at the ti	me, date a	nd place, ar	nd due to the cau	use(s) and m	nanner as s	tated.
	n 24 n 24 ne Fu	Medical	(Check only 2 Medical Exeminate)	ner: On the and ma	basis of examinat inner stated.	tion and/or in	vestigation, in my o	opinion, de	ath occurre	d at the time, dat	e and place	, and due to	o the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Σ	29b. Signature and title of certifier		^	0	29c. Licens	se number		290	d. Date sign	ed (Month,	Day, Year)
			of atheren	n a	sade	DO	H00	549	170	F	62	h 2	ach
	,1		30. Name and address of person who c	ompleted car	use of death (Item	23a) (Type,	Print)					2,0	
	M		Katherine Asad	1,2	OE.T.	mon	i'un R	oad	#2	09 Tir	nom'	unh	00b 00b
	Sta	_	3Y. Date filed (Month, Day, Year)		Registrar's Signa	SOL SEL				•			
	Registra	ar	FEB 2 8 2006	LICE STA		/							

			For	State of Maryland	•		Mental Hyg	giene	و جنس پنس فدن بخان
			State Registrar	·	Certifica	te of Death	1	Reg. Ne UUD	05861
	Physici /Medic		1. Decedent's Name (First, Middle, Las	" Elizaber	th r	liser	2. Date of Dea Month FEB	Day Year	3. Time of Death 5-00P M
	Examin		4a. Facility Name (If not institution, give	street and number USI	ng 4b. cit	y, Town, or Location of Death		4c. County of Deal	more
	Funeral Director		5. Social Security Number 6. S 3994-28-9965 1 Usual Residence of Decedent	7. Age (In yrs. lat	st birthday) If Und Month	er 1 Year If Under 24 Hrs. S Days Hours Min.	8. Date of Birti	3,1931 W	thplace (State or Foreign outling)
	Maryland f ehow	or	10a. State 10b. County	1more Co	Town or Location	1			10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f ehow rinust be notified at	i Director	10e. Street and Number	Rd	101.2	D Code		10g. Citizen of What Co	ountry?
9		Funerai	11. Marital Status 1 Newer Married 2 Married	12. Was Decedent Eyer in U.S. Armed Forces?	If Yes, sp	edent of Hispanic Origin? (Specify Cuban, Mexican, Puert	pecify Yes or No- Pican, etc.)	Black, Whit	
21215-0036	72 hours after natural, or ite dical Examina	eted by	3 Widowed 4 □ Divorced 15. Decedent's Ec (Specify only highest gra	If Yes, Give Year or Dates: lucation de completed)	16a. Decedent's Us		king	Specify: U	/industry
	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life. DO NOT	nemake	Cran Middle		ome
Maryland	2 should be fit and Mental H ie marked ott aumatic ever	To Be	James N	Ickenrick	Dich	Kae	S	Maiden Surname)	7-2-4)
-	t and 2 st Health and em 27 ie n ther traun		19a Informant's Name/Relationship (20a. Method of Disposition	nes Misey	2401 Dice of Disposition (A	ss (Street and Number or Ru	11 MON	COC. Location - City or	1221
Baltimore	it. Pa rtmer rtant: njury		1 VBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Sign ture of Funeral 5 rvice licen	Removal from State Poor	r KUOO	other place) CMRKN and Address of Ficility Eve	25/06	Parkoi	Vemo.
Ba	Dermi Depa impo any ii		23a. Part1. Enter the disease, or com		8800	Hartord Re	1. Park	Wille, mp	2/234 Approximate
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a CVA					Interval Between Onset and Death
	Examiner	J.	Sequentially list conditions, if any, leading to immediate	b. DIABETE Due to (or as a conseque	S MEL	LITUS			monuns
	cate be executed oblysicien and the burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. CHRONIC	2 072				moneto
68760	icate be e physicier s the buria		(d. FAILUR	E 70 7	THRIVE			
O. Box (at the death certifics by the attending pt tached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 moons? 1 □ Yes 2 □ Mo 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3 ☐Ectopic			23d. Date of de Month	livery Day Year
ds, P.	os th	by	Part II. Other significant conditions o	ontributing to death but not result	ting in the underlying	g cause given in Part I.		obacco use contribute to	
of Vital Records,	The law requir ate has been si page 2 should	Completed					24a. Was autop	med? death?	atopsy findings available comptetion of cause of
ital		0	25. Was case referred to medical	***		26. Place of Dea	1 ☐ Yes th (Check only o	-	3 2 □ No
Ž	× 5 ₽	ToB	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3	DOA Other: 4 Nursing H	ome 5 Resid	lence 6 Other (Spe	cify)
ion o	ding After funer		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe h	ow injury occurred	
Division	To the Hospitel or Attenwithin 24 hours after deall To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not b. 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, fact	ory, office	28f. Location (S City or Tow	itreet and Number or R n, State)	ural Route Number,
	the Hospitel in 24 hours in the Funeral ipletely filled	edical	(Check only 2 Madical Examone)	ysician: To the best of my know niner: On the basis of examination and manner stated.	on and/or investigati	on, in my opinion, death occu	rred at the time, o	date and place, and due	e to the cause(s)
	To the within 2. To the I complete	Σ	29b. Signature and title of certifier	2	*	29c. License number		29d. Date signed (Mont	h, Day, Year)
7			30. Name and address of person who) He Mb	23a) /Tune Print)	0003315	O	FEB 22r	19 5006
	1		Shalwnma	es Sup	e 965	o santiz	350 8	soad, a	olumbia
	Sta Regist		31. Date filed (Month, Day, Year) FEB 2 8 20	completed cause of death (Item:	Joseph Joseph				21045

			State of Maryland / Department of Health and M	•	9	
			1- State Registrar Certificate of Death	Reg	. No. U U 6	05862
	Physici		1. Decedent's Name (First, Middle, Last) Mabel B. Mattingly	2. Date of Death Month	Day Year 24, 2006	3. Time of Death
}	/Medic Examin		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center 4b. City, Town, or Location of Death Towso		4c. County of Deat	imore
	Funeral Director		5. Social Security Number 578-01-7912 6. Sex 1 M 2 XF 7. Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, y July 09,	(ear) 9. Birtl Co 1914 Wash	nplace (State or Foreign untry)
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Man ta-f sh tiffed	ctor	Maryland Baltimore County Timonium			1 ☐ Yes ŽŽÍNo
	with th	Funeral Director	10e. Street and Number 10f. Zip Code 2525 Potspring Road 21093	100	. Citizen of What Co	•
	leath	eral	1 0	ecify Yes or No-	United St	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28a-1 show any injury or other treumatic event, the Medical Examination instituted at once.	by Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Year or Dutes: 1 Yes 2 No Specify:	Rican, etc.)	Black, White	
20	72 ho	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	ina 16	b. Kind of Business/l	industry
21215-0036	within ane. Ihen "	Completed by	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	(Carnegie I	
0	filed Hygie	e Co	12 N/A Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Ma	of Washi	ngton
<u>lan</u>	uld be Aental rked o	To Be	Joseph Lamond Bateman Catherin	e Murphy		
Maryland	2 sho and h is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run 100.000 3.1 1.1 1.1 1.2 1.2 1.2 1.2 1.2 1.2 1.2 1			
e,	1 and Health em 27 ther to		Marilyn T. Mattingly(Daughter) 12809 Dulaney Valley R 20a. Method of Disposition (Name of		C. Location - City or	
nor	Pages ant of nt: If it y or o		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) Evans Funeral Chapel			11, Maryland
Baltimore,	permit. F Departm Importer any injur		21. Signature of Funeral Service Licenses July J. Jan, Jr. Peaceful Alternative 2325 York Road Time	es Funera	1&Cremati	
			23a. Pan . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.			Approximate Interval Between
10	Pnysician		Immediate Cause (Final disease or condition SEFSIS			Onset and Death
	/Medical Examiner		Due to (or as a consequence of): URINARY TRACT INFECTION			
		er	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
8760,	icate be executed physician and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d			
.O. Box 6	death certif e attending d for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify)		23d. Date of deli	very Day Year
rds, P	w requires that been signed to should be det	ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DUODENAL ULCER	23e. Did tobac	cco use contribute to	the cause of death?
l Records,	The la ate has bage 2	Completed	ATRIAL FIBRILLATION/FLUTTER	24a. Was an autopsy performe	d? prior to o	opsy findings available ompletion of cause of
Vital	Physicien: Th r this certificate sral director, pag	Be	25. Was case referred to medical examiner? Hospital: When the property of the			
	dis di	5. To	1 I les 2 I No 1 I I I I I I I I I I I I I I I I I I	me 5 Residence 28d. Describe how		ify)
ion	Attending Physicien: r death. ector: After this certifics by the funeral director, p	atlor	1 X Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No		,	
Division of	el or Atte s after de l Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control of the control one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a control one)	and due to the caus ed at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month	
•			D 37254		2/25/	26
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1475 PM 1 4 4 4 4	3. [307) . 100, 38 .007. 200	
	Sta	te	BOON POH LIM, M. D. 76-71 OSLER DRIVE, TOWSON. 31. Date filed (Month, Day, Year) FEB 2 8 2006 32. Segistrar's Signature	MHKYLF	IND ETEM	t
	Registr	ar	FEB 2 8 2006			

State of Maryland / Department of Health and Mental Hygiene 05863 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 12:10 AM MCKN14HT JOYCE R 2006 FFBRUARY 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 XF 219-74-4506 Director 48 08-01-1957 Maryland Usual Residence of Decedent build be filled within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or Itama 23a or 28a-f show event, the Missingl Examinating the notified at 1 X Yes 2 ☐ No Completed by Funeral Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 **TISA** 705 Calhoun Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. Is marked other than College (1-4or 5+) Child Care Day Care Provider 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menia Important: If Itam 27 Is marked any injury or other traumatic evones. Irma McKnight 2 Melvin Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 N. Calhoun Street Baltimore, MD 21217 Leonard B. McKnight/ Brother 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03-03-06 Catonsville, MD Western Star Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for its a considerance of Examiner the attending physician and thed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed AIDS Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical ate has been signed by the attending phys page 2 should be detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of deliven 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Denknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 20 No 1 Tes 2. No 1 Tyes : After this certifical funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ANaturai 5 Pending s after death. 1 ☐ Yes 2 ☐ No М investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P15142 FEBRUARY 24,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZICSERSTE 1~, GREENE BALTMORE, MO MO 5 16 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 2 8 2006 The Ress. Registrar

			1 - For State Registrar	State of Marylar		artment of F			jiene leg. No ()	06	058	64
			Decedent's Name (First, Middle, Last)					2. Date of Dea	th		3. Time of D	eath
	Physici /Medio		Anna Lillian	Mears				Februar	cy 25,	2006	22:10	М
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of De	ath		ty of Death		
			Gilchrist Center			Towson	T KILL TO SEE			imore		
	Funeral Director		214-22-9922	7. Age (In yrs.)		If Under 1 Year Months Days	If Under 24 H Hours Mi		, Year)	9. Birthp Court Mary	lace (State or I try) Land	Foreign
	land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				1	0d. Inside City	Limits
	Mary	ō	Maryland Baltimor	e Pa	arkton						1 Yes 2	2 🕅 No
	h the	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of	What Coun	try?	
	23a c		1112 Mount Carme	l Road		21120			USA			
	r dez	Funeral	11. Marital Status	Was Decedent Ever in L Armed Forces?		Was Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ce - Americ		
36	within 72 hours atter death with the Maryland ene. Than "natural", or items 23e or 28e-f show he dical Exercine round be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Speci	ific		
Ş	tura e E	ed	15. Decedent's Edu		16a. Dece	dent's Usual Occup	ation		16b. Kind of I	USA Business/Inc		
215	hin 7.	ple	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of и d)	vorking			,	
7	filed wit Hygiene other tha	Completed	9		Bak	er			Publi	.c Edu	cation	
Ind	be fift d offh	Be	17. Father's Name (First, Middle, Last)	D	_		_	lame (First, Middle,		,	···	
3	should ind Men marke umatic	2	William Arth 19a. Informant's Name/Relationship (Ty				Helen		ield		French	
Maryland 21215-0036	nd 2 silith an allth an 27 is r			, , ,	1 - 000			Rural Route Number		-30		74
ē,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Tractural, or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once.		Shirley M. Whitehu 20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other place		Date Parki	20c. Location	- City or To	wn, State	
Baltimore,	Page: sent o nt: if ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	Mem. Gard	-	02/06 E	Bel Air	, Mar	yland	
alti	permit. Departmingorta Importa any inju		21. Signature of Funeral Service License			. Name and Addre		McComas			-	
<u> </u>	80 5 8 8		Steller le Mu	ad5	1	317 Coke	sbury Ro	oad, Abing	gdon, M	aryla	nd 2100	ງ9
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the dea ne cause on each line.	th. Do not ent	er the mode of dyir	ng, such as card	iac or respiratory arr	est,		Approximate Interval Between	en
	Priysician		Immediate Cause (Final disease or condition resulting in death)	rec	Aal	CANC	eR				Onset and De	hs
	/Medical Examiner		Tosulary in coality	Due to (or as a consec	quence of):							
		ē	Sequentially list conditions,	Due to (or as a consec	quanca of).					-		
W	outed ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
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Вох	eath certifi attending i for use as	Physician/Me	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of	aldeath 3□	Ectopic pregnancy Other (specify)	,			ate of delive onth	ry Day Ye	ar
o.	that the de ned by the a deteched i	hysi	1 ☐ Yes 2 ⚠ No 9 ☐ Unknown	9☐ Unknown								
ď.	The law requires that the death certificate hes been signed by the attending page 2 should be deteched for use as	ру Р	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use cor	ntribute to th	e cause of dea	ath?
ord Ord	w require been si should b	ted						1 🗆 Yo	es 2 No	3 Prob	ably 4 ∐Un	known
ecc	e taw r hes be je 2 sh	Completed						24a. Was a autops	sy	prior to cor	osy findings av	
<u>~</u>								performula 1 Tes	med? 2X No	death? 1 ☐ Yes	2□ No	
₹	Physician: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		. acl post Oth	00	eath Check only or	11.55		rf .	
ō	Phys rthis oral dii); To	1 ☐ Yes 2 🔯 No 27. Manner of Death	28a. Date of Injury	28b. Time of	I 3L DOX	4 Nursing	Home 5 Reside			Hosp	1100
<u>o</u>	nding ath. r: Afte e func	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2∐No					
Division of Vital Records,	r Attendi er death rsctor: / by the fa	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, str	eet, factory, office		28f. Location (Si City or Town		ber or Rura	Route Numbe	9 <i>r</i> ,
	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer											
	To the Hospitei within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examir	nician: To the best of my known. Ter: On the basis of examination and manner stated.	owledge, death ation and/or in	n occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the courred at the time, d	ause(s) and mate and place	anner as st , and due to	ated. the cause(s)	
	omple	Me	29b. Signature and title of certifier	A A		29c. Licens	e number	2	9d. Date sign	ed (Month, I	Day, Year)	 .
)	F>F0		M Anthony	Wiley.	ung	05	20621	- F	Febru	my 2	6,200	6
	.2		30. Name and address of person to	mpleted cause of dea h (Ite	m 23a) (Type,	Print)	C. 2	telto.m		,		
			7	BMC 6701		harles	St. Bo	elto. m	d 2 c	207	e 	
2	Sta Registr		31. Date filed (Month, Day, Year) FEB 2, 8, 21	32. Registrar's Sign	ature	code						

Mears, anna

			For	State of Maryla					Mental H	/gieņę	0000	ngocs
			1 - State Registrar		(Certifica	te of D	eath		Reg. No	.000	00000
	Physicia	an	1. Decedent's Name (First, Middle, Las	MCLI	= /_	LA	Λ/		2. Date of D	Day		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give		-			ocation of Dea	teleme	1	County of Deat	
	LAGITITI	ÇI	BON SECO		ITAL		BAL	-TIN	ORE			
	Funeral	3	Social Security Number 6. Security Number			Months		If Under 24 Hrs Hours Min	. (Month, E			hplace (State or Foreign untry)
sof .	Director		220-30-6624 Usual Residence of Decedent	JM 2X/F 8:	3 Y	rs.			Apr 26	, 19:	22 Ma:	ryland
	yland 10w		10a. State 10b. County	10c. C	City, Town	or Location						10d. Inside City Limits
:	Ba-f el	ctor	MD	Ва	ltimo	re						1 ☐ Yes 2 ☐ No
2	Mith th	by Funeral Director	10e. Street and Number			10f. Z	ip Code	11000		10g. Cit	izen of What Co	ountry?
	eath v	erai	340 S. Bentalou S	12. Was Decedent Ever in	u.s.	13. Was Dec		21223	Specify Yes or N	0-	USA 14. Race - Ame	nican Indian.
	or Item	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No					Specify Yes or National Rican, etc.)		Black, White	
3	illed within 72 hours after death with the Maryland Hygione. Arthen "naturel", or Itema 23a or 28a-f ehow ant, it a Medical Exact at must be notified at	d by	3 ☐ Widowed 4 [X]Divorced	If Yes, Give Year or Dates:			2 🕅 No	Specify:			Specify: W	iite
2	"natu	iete	15. Decedent's Ed (Specify only highest grades)	ucation de completed)		Decedent's Us (Give kind of v life. DO NOT	rork done du	ion ring most of we	orking	16b. K	ind of Business/	Industry
7	r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		.E. ins	,	or			educat	ion
2	al Hyg I othe	Bec	17. Father's Name (First, Middle, Last)				1		ame (First, Middl			
2	2 should be filed within and Mental Hygiene. Ie marked other than raumatic event, I ca Mi	10	Charles Ritchies						Agnes M			
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Menhal Hygiene. If Health and Menhal Hygiene. If the 21 is marked other than "natural", or Itema 23a or 28a-f show from 21 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, If a Medical Exact or must be inclified at		19a. Informant's Name/Relationship (7						Rural Route Num			
נֿע	Heall Heall tem 2 other		Linda Makokski/da 20a. Method of Disposition		Place of	Disposition (N	ame of		et Balt:		ocation - City or	1223 Town, State
2	Pages ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 🛛 Donation 5 ☐ Other (Specify		свтетегу	r, crematory or	otner place)	, i				
5	permit. Pages 1 and 2 Department of Health a Important: if Item 27 le eny injury or other trai		21. Signature of Funeral Service Licen Ronald S	Wade, Directs	er:	22. Name	and Address	of Facility	d 655 W	. Bal	timore	Street
2	20 E 2 9		/way	11/1/100		Baltin	ore, l	MD 212	01		- Limor C	
	14. 18.		2 a. Part1. A ter the disease, or com- shock, a heart failure. List only of Immediate Cause (Final	(0) 00				such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
F	hysician /Medical	33.	disease or condition resulting in death)	a. PAELI Due to (or as a conse		0 N1.	4					
ı	Examiner			SEP	51	Š						
	D 15	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	edneuce o	f):						
_ i	be executed ician and burial-transit	Examine	that initiated events resulting in death) Last	c Due to (or as a conse	equence of	f):						
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5	the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	death	5 Other (specify)	-				54, .54.
	that the head by a deta	by Ph	Part II. Other significant conditions co	ontnbuting to death but not re	esulting in	the underlying	cause given	in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
200	equire en sig ould bo								1 🗆	Yes 2	□No 3□Pr	obably 4 Tunknown
ָ ט	ding Physician: The law requir h. Affar this certificate has been s funeral director, page 2 should	Completed							24a. Wa	s an opsy	prior to	stopsy findings available completion of cause of
ב ה	cate h	Cou							per 1□ Yes	formed? 2 No	death? 1 ☐ Yes	2 No
= =	certifi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	7500		Other		eath (Check only		- 70	
5 i	g Phy er this eral d	-	27. Manner of Death	28a. Date of Injury	28b. Ti	me of	28c. Injury a Work?	4 Nursing	Home 5 ☐ Res 28d. Describe			city)
<u> </u>	ath. r: After ne funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		tn	jury M		es 2 □ No				
<u> </u>	or Atter de lirecto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pface of Injury - At building, etc. (Spec	home, far	m, street, facto	ory, office		28f. Location City or T	(Street an	nd Number or Ru e)	ural Route Number,
ַ	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying Ph	ysician: To the best of my k	nowledge	death occurre	nd at the time	date and place	e and due to th	e cance(c)	and manner as	stated
	ne Hos 7 24 h ne Fur pletely	edicai	(Check only 2 Medical Examone)	iner: On the basis of examinand manner stated.	nation and	Vor investigation	on, in my opin	nion, death occ	curred at the time	, date and	d place, and due	to the cause(s)
1	vithir To th	Me	29b. Signature and title of certifier	0 1	-	. 2	9c. License		-	_	te signed (Mont	
			1 Kopuda	K. Cru	18	24.)	000	0303	55	FE	BRUA	14 16,200L
			30. Name and address of person who	completed cause of death (It	emi~23∕á) (1 <i>N</i>	Type, Print)	B	or Si	55 ECOU	RC	HOSP	HAZ
15	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	M			001		,,-0/	/ / /
	Regietr	24	O CUUU	E AVASEA A PEA	1500	Ballo B						

			1 - For State Registrar	State of M	arylan	-	artment of F				iene	06	05866
	Physici /Medic		Decedent's Name (First, Middle, ERIC McINTOSH							2. Date of Death	Pay 17		
	Examin		4a. Fadility Name (If notfinstitution	give straet and number	Cen	iter	4b. City, Town, o						imore
	Funeral Director		5. Social Security Number 219–82–5277 Usual Residence of Decedent	6. Sex 7. Ag 1 X M 2 □ F	90 (In yrs. I 43	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 8-16-1	Year) 962	9. Birthpl Coun. MARY	ace (State or Foreign try) LAND
	ryland how		10a. State 10b. County			, Town or La						16	Od. Inside City Limits
	the Ma	Funeral Director	MD . N/	A	ВА	LTIMOF	10f. Zip Code				On Citizen of	Mark Court	1 No 2 No
	Sa or 3	Dir	5719 E. BURY	ATTE			21206				og. Citizen of USA	wnat Coun	try ?
	death	nera	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of H		gin? (Spe	ecify Yes or No-	14. Ra	ice - America	
0000	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Evaniner must be notified at	by Fu	1 X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced		No	1	1 □ Yes 2 ∏ No	Specify:		riodii, oto.	Speci		ACK
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and	should be nd Mental marked o	To Be	DOUGLAS McINT	OSH				EL	IZAB	ETH GIBS	ON		
lary	2 should and Mer is marke aumatic		19a. Informant's Name/Relationsh				ng Address (Street				•		
≥ ອົ	1 and Health em 27 ther tr		CYNTHIA HARRI 20a. Method of Disposition	SON(SISTER)	20b. P	lace of Dispo	NARJEF sition (Name of				MARY LA Oc. Location		
	Pages nent of int: if it		1 37 1	3 □Removal from State	Cé	emetery, crer	natory or other place CEMETERY	2-	22-2				ARYLAND
Dalillo	permit. Pages 1 and 2 should Department of Heaith and Men importent: if Item 27 is marke any injury or other traumatic.		21. Signature of Funeral Service L		N D.	100000	Name and Addre						LAND 21217
			23a. Part . Efter the disease, or on short, I heart failure. List of	complications that cause only one cause on each li	d the death								Approximate Interval Between
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	F'NEUM Bleto (St as									Onset and Death
	Examiner		Sequentially list conditions,	b									
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as			E DEFIC	TENC	Y 51	ZNDROME		3	
ĵ.	be executed ician and burial-transit	Ехаг	that initiated events resulting in death) Last	CDue to (or as							-		
0/0	cate be executed bhysician and the burial-transit	dicai		d									
O. DOX 0	The law requires that the death certificate sle has been signed by the attending phys bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3	Ectopic pregnancy Other (specify)	,				ate of deliver	ry Day Year
cords, r	quires that n signed build be deta	by	Part II. Other significant condition	ns contributing to death b	out not resu	ulting in the u	nderlying cause giv	en in Part I		23e. Did tob	11		e cause of death? ably 4 □Unknown
neco	The law red ate has bee page 2 shor	completed								24a. Was an autopsy perform	/	prior to con death?	psy findings available appletion of cause of
V 11.01	ding Physician: The In. After this certificate he funeral director, page	BeC	25. Was case referred to medical examiner?	Hospital:			04			(Check only one	9)		
=	Physi r this c rat dir	. To	1 Yes 2 No	28a. Date of Inju		ER/Outpatien 28b. Time of			rsing Hor	ne 5 🗋 Resider	nce 6 ⊟Ot w injury occu	her (Specify)
SION	nding ath. r: Afte e fune	atior	1 Natural 5 Pending 2 Accident investiga		y Year)	Injury	Wor	k? Yes 2□			. ,		
DIVIS	al or Atte s after des if Directo	Certification;	3 Suicide 6 Could n 4 Homicide determin		ury - At ho ic. (Specify	me, farm, str	eet, factory, office		2	28f. Location (Str City or Town,		ber or Rural	Route Number,
	To the Hospital or Attending P within 24 hours alter death. To the Funeral Director: After completely filled in by the funera	edical (29a. Certifier 1 Certifying (Check only one)	Physician: To the best examiner: On the basis o and manner st	f examinat	wledge, death tion and/or in	n occurred at the tin vestigation, in my o	ne, date an pinion, dea	d place, a	and due to the ca ed at the time, da	use(s) and m te and place	nanner as sta , and due to	ated. the cause(s)
	To the within comp	M	29b. Signature and title of certifier	P mell	in n	M-0	29c. Licens	e number 141 (Z)		29	d. Date sign	ed (Month, L	Pay, Year)
			30. Name an add ass of person w	who completed cause of o	•		Print) OSLER D	RIVE	TOF	JSON, M	ARYLA	ND 2	1204
	Sta	-	31. Date filed (Month; Day, Year)	32. Ripgisti	ar's Signat	ture	made 8						
	Registr	aı	FEB 2 8	2006	asid d	I AS	CO SERV						

LINDA C. MUTRO 06-01288 RKD

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Unpend item# 23a.	State of Ma		16K Ind	18/06 TT	lealth and l	Montal Hy	s Are	Legible.	05077
		1 - For State Registrar	State of Ma	irytariu .		tificate of		vieritai riy		tion and had had	U 5 8 6 /
		Negistrar 1. Decedent's Name (First, Middle, Last)		007	mouto or	Deatri	2. Date of D	Reg. No eath	0.	3. Time of Death
Physicia /Medic		Linda C.	Mutro					Month FEBRUA	RY 2	20, 2006	9:56A. M
Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of Death			c. County of Deat	
		12132 SUGAR MILL C		(10	the last of a like	ESSEX If Under 1 Year	If Lindor 24 Hrs	10.00		ALTIMORE	
Funeral Director		5. Social Security Number 6. Se 219-40-7630	M 2DF	6 4 last	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	ay, Year	9. Birt Co	hplace (State or Foreign nuntry)
yland		10a. State 10b. County		10c. City, T	own or Loc	ation		•			10d. Inside City Limits
e-fet	ctor	MD Baltin	nore	E	330	-X					1 ☐ Yes 2 ☑ No
or 28	Dire	10e. Street and Number	N	1	,	10f. Zip Code			10g. C	itizen of What Co	ountry?
e 23e	erai	12132 Suga			-	2122				USA	rices (artice
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or iteme 23a or 28e-f ehow any injury or other traumatic event. Ite Modical Examinat must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give		If	Yes, specify Cuba	lispanic Origin? (S) an, Mexican, Puert Specify:	Decity Yes or N D Rican, etc.)	0-	14. Race - Ame Black, White Specify: W/	e, etc.
hour:		3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Edu	Year or Dates:	1	6a Decede	ent's Usual Occup	ation		16h l	Kind of Business/	
nin 72 in "na Madis	Completed	(Specify only highest grad	e completed) College (1-4or 5-		(Give k	ind of work done O NOT use retired	durina most of wor	king			
ad with	E O	12	/ /			LPN			/	VURSIN	9
be file d oth event	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nan		e, Maide	n Sumame)	
hould d Mer marke matic	ဥ	HT HUR DAUNE. 19a. Informant's Name/Relationship (T)	rna Orint)		IOh Mailine	Add (Ct	EVELY And Number or Ru	-	0%	T Ot	T- 0-4-1
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s 1 and if Health item 27 other tr		20a. Method of Disposition	21.57	20b. Place	e of Dispos	ition (Name of atory or other place	y , Ou !	Date	20c. L	ocation - City or	Town, State
Pages nent of I unt: If its		1 ☐ Burial 2 © Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	10	•	Cremat	/	3/06	B	HIN DE	n
permit. Departrimports any inju		21. Signature of Funeral Service Licens	*	7	22	Name and Addre		ton Fun	IERO	J Home	P.A.
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		23a. Part1. Enter the disease, or comp. shock, or heart failure. List only o Immediate Cause (Final	ne cause on each lin	е.							Approximate Interval Between Onset and Death
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ed sit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequen	ce of):						
te be executed ysicien and te burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a	consequen	ce of):						
ite be iysicie ne bur	cal		d								
artifica ing ph e as th	Med	IF FEMALE:								1	
w requires that the death certificate been signed by the ettending phys should be detached for use as the	by Physician/Medl	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at t	2 🗆 Fetal de		Ectopic pregnancy Other (specify)	,			23d. Date of del Month	ivery Day Year
the de by the ached	ysic	1 ☐ Yes 2 ☐ No 9 ☑ Unknown	9□ Unknown	une or deat	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Offier (specify)					
s that gned b	y P	Part II. Other significant conditions co	-		g in the und	derlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
equire en sig		non-insulin dependent	diabetes me	llitus				10	Yes 2	Pro 3 □ Pr	obably 4 🗷 nknown
e 2 sh	Completed							24a. Was	psy	prior to o	topsy findings available completion of cause of
n: The ficete r, pag								1/Z/Yes		o death?	2 □ No
s certil	To Be	25. Was case referred to medical examiner? 1 ↑ Yes 2 No	Hospital:	nt 2 ER	/Outpatient	3 Och Oth	er. A Nursing H			6 DVOthor (Con	A CCENTE
g Phy er this ieral d		27. Manner of Death	28a. Date of Injury (Month, Day	y 28	b. Time of Injury	28c. Injur Wor	y at	28d. Describe		6 XOther (Specured	SUM SCENE
eath. or: Af	catic	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(//////////////////////////////////////		,,		Yes 2 □No				
s after d al Direct ad in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc		, farm, stree	et, factory, office		28f. Location City or To	(Street a wn, Stat	nd Number or Ru 'e)	iral Route Number,
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificete has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☑ Medical Exemi	sician: To the best oner: On the basis of and manner state	examination	dge, death and/or inve	occurred at the tirestigation, in my o	ne, date and place pinion, death occur	and due to the red at the time	cause(s date an	s) and manner as id place, and due	stated. to the cause(s)
To the comp	ž	29b. Signature and title of certifier				29c. Licens	e number		29d. Da	ate signed (Monti	n, Day, Year)
		• West.)			0.C.	М.Е.		FEBI	RUARY 21	, 2006
		30. Name and address of person who co		eath (Item 23		•	STREET E	ΑΤ.ΤΤΜΟΙ	भ म	MARVI AND	21 201
Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature		LII ETMIN	THEFT I	WILLTIOE	۱ وت		41401

State Registrar DHMH 17 Rev 1/2001

FEB 2 8 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NGUYEN Physician Month ILLAN 10:00 PM February 23, 2006 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins - Bayview N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y NOV. 14, Birthplace (State or Foreign Country) 1**∑**M 2□F Days Hours 213-02-0051 Yrs. Director 27 1977 Vietnam Usual Residence of Decedent 10c. City, Town or Location 10a, State 10h County 10d. Inside City Limits or 28a-f show treumstic event, the Medical Exactiner must be notified at N/A Director Md. Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Iteme 23a death 2914 Layshire Road 21230 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
mts if item 27 is marked other then "natural, or iteatury or other freumatic event, the Medical English ury or other freumatic event, the Medical English ury 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Son Van Nguyen Loi Thi Pham 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trung T. Hguyen / Brother 2914 Layshire Road, Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of hamportant: If Ite eny Injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 2/28/06 4 □ Denstion 5 □ Other (Specify) Baltimore, Maryland nature I Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between EN CE PHALOPATHY Onset and Death Immediate Cause (Final ANOXIC **Physician** disease or condition resulting in death) /Medical Examiner DISORDER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examine anding physicien and use as the burial-transit S Hospitel or Attending Physicien: The taw requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown sate hes been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Be Completed 3 Probably 1 Tyes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 21 No 1 Yes 20 No 1 Yes : After this certifical tuneral director, f 25. Was case referred to medical examine? 26. Place of Death (Check only one) Ves 2□ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ‡ 1 29b. Signaty and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month. legistrar's Signature State Registrar

			1 - State Registrar		partment of Health and fertificate of Death	Mental Hygie	2000	05869
	Physici		1. Decedent's Name (First, Middle, Last)	Nolos		2. Date of Death	Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		4c. County of Death	P.05
	Funeral Director		5. Social Security Number 6. Sex		Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birthy	place (State or Foreign ntry)
	Maryland -f show lied at	tor	Usual Residence of Decedent 10a. State 10b. County 10ANAMO 10b. County	10c. City, Town or				10d. Inside City Limits 1 ☐ Yes 2 No
	with the la or 28a	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	ntry?
36	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Evarrinar must be rotified at	by Funeral	11. Marital Status 1 Never Married 2 Married 358 Widowed 4 Divorced		3. Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
Maryland 21215-0036	within 72 hou ne. .han "natura e Medical E	Completed	15. Decedent's Edu (Specify only highest grade	cation 16a. De (G) College (1-4or 5+)	ive kind of work done during most of work be DO NOT use retired)	king 16b	, Kind of Business/In	
land 2	be filed ntal Hygi od other event, L	To Be Co	17. Father's Name (First, Middle, Last)	HENTECHEL	Ta. Mother's Nam	ne (First, Middle, Maid	AT HOP	1.7
	1 and 2 sh Health and em 27 is m ther traum		19a. Informant's Name/Relationship (Ty,	20b. Place of Dis	ailing Address (Street and Number or Ru R Sposition (Name of prematory or other place)	Date 200	ty or Town, State, Zip	MANO
Baltimore,	permit. Pages Department of I Important: If Ite any injury or of		12 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Sign three of Fundry Service License	1 K70K1		DODE BURGES	WILL MAN	y harlance
	Physician /Medical		23a. Part1. Enter the disease, or compile shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not le cause on each line. Cerolice. Due to (or as a consequence of):	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
8760,	executed sample and shrinkly sician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. It is a factor of the condition of the cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	rteny discox			10 years
.O. Box 687	The law requires that the death certificate i tie has been signed by the attending physi page 2 should be detached for use as the t	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\$\text{\$\exititt{\$\text{\$\exititt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive	əry Day Year
<u>α</u>	w requires that i been signed by should be deta	þ	Part II. Other significant conditions con	1 - 01 .	e underlying cause given in Part I.		co use contribute to the	he cause of death?
Vital Records,		Completed				24a. Was an autopsy performed 1 Yes 2 🗷	prior to co death?	opsy findings available mpletion of cause of 2 No
Vita	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Other	th (Check only one)	6 □Other (Special	(v)
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injur	e of 28c. Injury at	28d. Describe how in		
Divis	tal or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St		al Route Number,
	he Hospl n 24 hou he Funer	edical	29a. Certifier (Check only one) 7 Certifying Physical Cartifying Physical Examination (Check only one)	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occur	, and due to the cause rred at the time, date a	e(s) and manner as s and place, and due to	tated. the cause(s)
)	Tot withi Tot	W	29b. Signature and title of certifier	Richard (Bangias)	29c. License number	29d. I	Date signed (Month, 2/27/C6	Day, Year)
	12		30. Name and address of person who co		De, Print) Dr., 10755 Fells Rel Laker	lle hd zics?		
	Sta Registi		31. Date filed (Month, Day, Year) EER 9 2 2006	32. Registrar's Signature				

MARIE DOROTHY NOLAN

MD 10d. Inside City Limits 1 Nes 2 No 10g. Citizen of What Country? United States Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Unknown 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 596 Tulip Poplar Crest Carmel, IN 46033 20c. Location - City or Town, State Beltsville, Maryland 22. Name and Address of Facility
Cremation and Funeral Alternatives Baltimore, Maryland Approximate Interval Between Onset and Death ureexs 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 2\ \ \ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۵ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of ertifier 29c. License number ath (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 8 2006 DHMH 17 Rev 1/2001

5:50 PM M

Birthplace (State or Foreign Country)

2006

Registrar

Division of Vital Attending Physicien: After this certific funeral director,

death.

To the Hospital or within 24 hours a To the Funerei C

i Director: ,

			1 - For State Registrar		State of	of Maryla	and / Depa	artment rtificate					giene	000	05871
		4	Decedent's Name (First	t, Middle, La	st)						2	Date of Dea	ath		3. Time of Death
	Physici /Medic	al		ee			llips	Ab Cib. T		1		Februa	-	24, 2006	
W.,	Examin	er	4a. Facility Name (If not in 47 Seaford	_		imber)		4b. City, To		Location	of Death			Baltimo	
	Funeral	127	5. Social Security Number			7. Age (/n y	rs. last birthday)	If Under 1	Year	If Under		. Date of Birt	h	9. Birtl	nplace (State or Foreign
4.4	Director		214-38-5491	1	□ M 2 /CX F	6	3 Yrs.	Months	Days	Hours	Min.	an. 21	194	43 Mary	Tand
	and *		Usual Residence of Deced	dent County		10c.	City, Town or Lo	cation							10d. Inside City Limits
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	28e	Directo	10e. Street and Number					10f. Zip C	ode				10g. Citi	izen of What Co	untry?
	h with	a D	47 Seaford A	venue				21.	221				U.	S.A.	
	eme 2	Funeral	11. Marital Status		12. Was Dec	edent Ever in		Was Decede	nt of His	spanic Ori	gin? (Speci	fy Yes or No-	-	14. Race - Ame Black, White	
36	72 hours after death with the Maryland naturel', or iteme 23a or 28e-1 show disal Exactinar must be redified at	by Fu	1 ☐ Never Married 🔏 3 ☐ Widowed 4 ☐ D	_	1 □ Yes If Yes, Gi Year or D	≱⊠ No we		1 □ Yes 🗶		Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,			ite
21215-0036	72 hours 'natural',		15. D	ecedent's Ed	ducation		16a. Dece	dent's Usual	Occupa	tion			16b. Ki	ind of Business/	
215	within 72 ho ene, than "natur he Medical	Completed	Elementary/Secondary		de completed) College (1-4or 5+)	life.	kind of work DO NOT use	retired)	urin g mos	t of working				
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Ž	2 should and Men is marks sumatic	ပ္	19a, Informant's Name/Re			•	19b. Maili	na Address (Street ai				r. Citv o	r Town, State, Z	Tip Code)
	# 2 mg		David Philli	rs (Hi	usband)								-	yland 2	
ore,			20a. Method of Disposition	7		-	p. Place of Dispo	sition (Name	of		Dat			ocation - City or	
Ë	Pages ment of it ant: if its ury or o		1 🖾 Burial 2 □ Crer 4 □ Donation 5 □ C			State H	olly Hi	ll Mem	. Ga	rd.F	eb.27	,2006	Bal	timore,	Maryland
Baltimore,	1 ABural 2 Cremation 3 Removal from State Holly Hill Mem. Gard. Feb. 2									nski 1 rn Av	Funera enue,	l Ho Esse	ome, P.A ex, Mary	land 21221	
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9		Φ.	IF FEMALE:		23c. If yes, ou	tcome of nre	gnancy							204 Date of dall	
Вох	The law requires that the death certifi tte hes been signed by the ettending age 2 should be detached for use as	Physician/M	23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☑ No		1 Live	birth 2 ☐ F nant at time o	etal death 3	Ectopic pred Other (spec					1	23d. Date of deli Month	Day Year
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ord	w requir been si should	ted	Musp	uc	VH.	2					_	1 🗆 Y	/es 2[□ No 3 □ Pro	obabiy 4 Dunknown
Vital Records,	elaw hesb	Completed	YVD				0					24a. Was autop	SV	prior to d	topsy findings available completion of cause of
al F			CKES	TS	igna	mon	e					1 Yes	rmed? 2☐Ho	death? 1 ☐ Yes	2 🗆 No
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The state of the s								4 🗆 190		d. Describe h		6 □Other (Spec y occurred	erfy)		
ion	Attending r death. ector: Aftel by the fune	atlo	1 → atural 5 ☐ 2 ☐ Accident	Pending investigation		ith, Day Year) Injury	м		es 2 🗌	No				
Division	f or Atten after deat Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place	e of Injury - A ling, etc. (Spe	t home, farm, st	eet, factory,	office		28	f. Location (S City or Tow			ral Route Number,
	Hospital or 24 hours afte Funeral Dir itely filled in		29a. Certifier 1	artifying Ph	veicien: To the	a bast of my l	knowledge, deat	h occurred at	the time		d place an				
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 M	ledical Exam	niner: On the b	pasis of examiner stated.	ination and/or in	vestigation, in	n my opi	inion, dea	th occurred	at the time,	date and	I place, and due	to the cause(s)
	To the H within 24 To the Fi	Ň	29b. Signature and title of	certifier	1 1	_		29c.	License	number			29d. Dat	te signed (Monti	n, Day, Year)
)	101		T	ful	llul	to.		0	000	570	02		2	124/0	6
	0		30. Name and address of	person who	completed cau	se of death (I	tem 23a) (Type,	Print) T	hi	14 Cla	epl	Lie R	d	Stetha	8D
	Sta		31. Date filed (Month, Day	, Year)	32.	egistrar's Si	gnature	2 49 .				·-		1- 2	
4	Registr	ar	FEB	282	006	Pallese 9	N. A	SALL)							

			1 - For State Registrar	State of Maryland /		t of Health and Ne of Death		ene g.2.006	05872
	Physic	ian	1. Decedent's Name (First, Middle, La	1 111:00			2. Date of Death Month	Day Year	3. Time of Death
)	/Medi Examii		4a. Facility Name (If not institution, giv	a street and number)	4b. City,	Town, or Location of Death	02	24 2006 4c. County of Death	10:15 PM
			Good Samari	tan Hospital	Ba	Himore			
	Funeral Director		5. Social Security Number 6. S 2/9-/4-7226 1 Usual Residence of Decedent	ex 7. Agé (In yrs. last t	Yrs. If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, June 28;		place (State or Foreign ntry)
	anytand •how		10a. State 10b. County	10c. City, To	wn or Location		-		10d. Inside City Limits
	death with the Maryland ma 23a or 28a-f show Listal be notified at	ecto	10e, Street and Number	nore Ba	Himore 101. Zip		10	g. Citizen of What Cou	1 Yes 2 No
	th with 23a or	ai Di	1222 Brookt	Mars fored	101. 210	21286		115A	nuyr
336	s after , or ite	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Deced	lent of Hispanic Origin? (Spirty Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Ameri Black, White	
5-0036	72 hour	eted	15. Decedent's Ed (Specify only highest gra	lucation 16	a. Decedent's Usua (Give kind of wor	I Occupation	kina 1	6b. Kind of Business/Ir	dustry
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Man	12 sho		19a. Informant' Name/Relationship (Type, Print) 19	b. Mailing Address	(Street and Number or Ru	ral Route Number,	City or Town, State, Zi	Code)
Baltimore, I	es 1 and 2 should of Health and Men of Item 27 Is marks ir other traumatic		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □	nom at	of Disposition (Namery, crematory or of	ne of ther place)	Date 2	Oc. Location - City or T	own, State
Ę	permit. Pages Department of Important: If If any injury or c		4 ☐ Donation 5 ☐ Other (Specific) Garden	s of Faith	Cometery More	h 1,2006 K	usedale, n	Daryland
Bal	permit. Departitimport		21. Signature of Funeral Service Licer	75 45 0	22. Name and	Address of Facility E	rans cho	11 00	morries
	W		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do	not enter the mode	of dying, such as cardiac		le Maryla	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Intracrania	al 1-10	morrhage			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):				
	***	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. <u>Uncontrolled</u> Due to (or as a consequence	e of):	blood pre	85 UVE		
V	executed in and ial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c					
760,	cian cian curia	ical Ex	resulting in deathy Last	Due to (or as a consequence	e of):				
89	hys he	100		d					
P.O. Box	atter for u	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	th 3 □Ectopic pre 5 □ Other (spe			23d. Date of deliving Month	ery Day Year
	res that the digned by the be detached	by Ph	Part II. Other significant conditions c	ontributing to death but not resulting	in the underlying ca	ause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
ord	w requires to been signer should be						1 ☐ Yes	2 2 No 3 Prot	pably 4 □Unknown
of Vital Records,	The far ate has page 2	Completed					24a. Was an autopsy perform	prior to co	ppsy findings available impletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor	h Check only one		
ou of	To the Hospital or Attending Phys within 24 hours atter death. To the Funeral Director: After this completely filled in by the funeral direct	lon: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b.	Time of 28	Bc. Injury at Work?	me 5 ☐ Residen 28d. Describe how	ce 6 Other (Special vinjury occurred	y)
Division	Attend r death actor:	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f	farm, street, factory.	1 ☐ Yes 2 ☐ No	28f. Location (Stre	eet and Number or Rura	al Route Number.
Ö	ital or ars after ral Dire	Certification:	4 HOMICIOS	building, etc. (Specify)			City or Town,		
	e Hosp 24 hou e Fune	edical	29a. Certifier 1 Crick only one) 1 Medical Exam	ysician: To the best of my knowledg finer. On the basis of examination a and manner stated.	ge, death occurred a indvor investigation,	at the time, date and place, in my opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as s e and place, and due to	tated. o the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier).	i	License number	1	d. Date signed (Month,	Day, Year)
			Jus J	rang, M.D	R	ES-000		02,24,20	006
	7	4	30. Name and address person who string Jiang 5601 / DCA Re			e mariel	and -	1229	
	Sta Registr	-	31. Date filed (Month, Day, Year) FEB 2 8 200	32. Registrar's Signature	Cordes	- pro(cory)	71100	1201	
347	negisti	aı	0 200	Josephon of	ALC: NO.				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 5:30F M Joseph Patti Sr. FEBRUARY 25,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 01/30/1908 Birthplace (State or Foreign Country) **Funeral** 1√2 M 2 □ F 98 218-18-3030 Director Italy Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ehow. r then "naturel", or iteme 23a or 28a-f eho the Medical Examiner must be notified at MD Baltimore Loch Raven 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6600 Loch Hill Rd. 21239 USA death 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 □ Yes 2 **X**Xio If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: White Specify. δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shoe Repair Dry Cleaner 10 permit. Pages 1 and 2 should be filed Deperment of Health and Mental Hyg Importent: if Item 27 is marked other eny Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Patti Agatha Cammarata 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agatha Metzdorf / Daughter 106 Duryea Dr. Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. Gardens 03/02/2006 | Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kimberly Davidson 5305 Harford Rd. kun Lawol80 Ruck Funeral Home Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE **Physician** /Medical Due to (or as a consequence of) Examiner ISCHEMIC CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed ettending physicien and for use as the burial-transit CORONARY ARTERY DISEASE Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e detached f 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ page 2 should be Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospital or Attendi within 24 hours efter death. To the Funeral Director; A М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number D37254 106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 BOON FOH LIM, OSLER DRIVE, TOWSON, 21204 M. D. MARYLAND 31. Date filed (Month, Day, Year) 32. degistrar's Signature State Registrar 2006

			1 – For State Registrar	State	of Marylar		artment of H tificate of L		_	giene Reg. No.		058	7
			Decedent's Name (First, Middle, La	st)					2. Date of De			3. Time of	Death
	Physici			Hilda H	Pass				Februar	:y 24	2006	2:03	A^{M}
	/Medic Examin		4a. Facility Name (If not institution, give	e street and n	umber)		4b. City, Town, or	Location of Death	1	4c.	County of Death		
			Suburban Hospit	a1			Beth	esda		1	Montgome	ry	
	Funeral		Social Security Number 6.		7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da November	th V Year)	9. Birth	place (State or	r Foreign
	Director		020-30-7300	I□M 2 ∑ F	92	Yrs.	World Days	TIOUTS IVIAT.	November	²⁵ , 1	.913 Mary	land	
	put *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation					10d, Inside Cit	hy Limite
	sho	5	Maryland Montgom	erv			Spring					1 ☐ Yes	
	28a-1	Director	10e. Street and Number			DIIVEI	10f. Zip Code			10a Citi	zen of What Cou		
	death with the Maryland me 23a or 28a-f show fraust be rictified at	₫	8505 Springvale	Road			2091	0			ited Sta	•	
	ne 23	Funeral	11. Marital Status	12. Was De	cedent Ever in U	.S. 13. V	Was Decedent of Hi	spanic Origin? (Sp	pecify Yes or No		14. Race - Ameri		
0	r Iter	표	1 Never Married 2 Married	Armed F 1 ☐ Yes	2 💟 No	11	f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		Black, White	etc.	
21212-0030	e sun	þ	3 Widowed 4 ☐ Divorced	If Yes, C Year or	Sive Dates:	1	1□Yes 2∏ No	Specify:			Specify: Wh	ite	
P n	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation	1)	16a. Deced	lent's Usual Occupa	ation furing most of wor	kina	16b. Ki	nd of Business/Ir	dustry	
7	ithin	nple	Elementary/Secondary (0-12)	College	(1-4or 5+)	life. L	DO NOT use retired)	g				
7	led w lygier her ti			. 2	<u>'</u>	Homer	naker	40. 14. 15 1. 11	(F) - 1 14 - 1-11		n Home		
and	be fi	Be	17. Father's Name (First, Middle, Last Saul Peltz	,				18. Mother's Nam	Black	Maiden	Sumame)		
Ž	hould d Mer mark matic	ဥ	19a. Informant's Name/Relationship	Tuna Brint)		10b Mailin	g Address (Street a			os Cituo	Tour State 7	- Cadal	
Z	d 2 s th and 7 le r traur		David J. Pass/S				ayne Plac					-	
ย์	1 an Heal tem 2		20a. Method of Disposition		20b. F	Place of Dispos	sition (Name of		Date 27,		cation - City or T		
<u> </u>	ages ant of it: If II		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		n State		natory or other place Cemetery		ery 27,	Cotu	it, Mas	sachuse	etts
aitimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Iteme 23a or 28a-f show eny injury or other traumatic event, the Macical Examiner must be notified at ance.		21. Signature of Fundal Service Lice			T-	Name and Address Dert A. Pum						
ă	Depar Depar Impo		Cargo attat say	NO	MO	1305 755	7 Wisconsi	pnrey rune n Avenue, I	Bethesda,	Mary.	sda-Cnevy 1and 20814	-3501	.nc.
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	/Medical		resulting in death)	Due to	o (or as a conseq	uence of):							
	Examiner		Sequentially list conditions,	b									
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conseq	uence of):							
_	and and Il-tran	хап	that initiated events resulting in death) Last	c. Due to	o (or as a conseq	uence of):					_		
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ò	ficate physics the	edical		_ d								-	
XOD	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna						23d. Date of deliv	ery	
ă	death e atte d for	cia	in the past 12 months? 1 ☐ Yes 2 🖾 No	4☐Preg	birth 2 Peta gnant at time of d		Ectopic pregnancy Other (specify)				Month	Day Y	'ear
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ກ້	as tha	oy P	Part II. Other significant conditions	contributing to	death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco u	se contribute to	he cause of de	eath?
	equire en si ould b	pel	Dementia			·			10	Yes 2[□No 3□Pro	bably 4 ∭U	nknown
ecoras,	aw Is b	Completed by							24a. Was		24b. Were aut	opsy findings a	vailable
r	ate pag	Con							perfo	rmed?	death? 1 ☐ Yes		
VIE	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	ne)			
	Physic this c	P	1 ☐ Yes 2 💢 No	-		ER/Outpatien		4 🔲 Nursing m			6 ☐Other (Speci	fy)	
	Jing F	o	27. Manner of Death 1 Natural 5 Pending	(Mo	e of Injury onth, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe	now injur	y occurred		
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<u>≥</u>	after after Direct	Certification;	4 Homicide determined	buil	ding, etc. (Specif	(y)	sol, laciory, office		City or To			ar riodio regina	701,
	To the Hospital or Attending Physwithin 2 hours alter death. To the Funeral Director: After this completely filled in by the funeral di		29a. Certifier 1X Certifying P	nysician: To th	ne best of my kno	wledge, death	occurred at the time	ne, date and place	and due to the	cause(s)	and manner as :	stated.	
	he Ho in 24 he Fu pletel	edical	(Check only 2 Medical Exa	miner: On the and ma	basis of examina inner stated.	ition and/or inv	estigation, in my or	oinion, death occu	red at the time,	date and	place, and due t	o the cause(s)	
	with To t	Σ	29b. Signature an 1 title of certifier				29c. License				e signed (Month,		
	6		800	5.Wil	lks in	D	D00	63195		Febr	uary 24,	2006	
	6		30. Name and address of person who					and Dath	osda M	0.227	and 2021	4	
			Steven D. Wilks,	A STATE OF THE STA	AND DESCRIPTION OF THE PARTY OF		getown Ro	Jau, Beth	esua, M	aryı	and 2001	-	
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			1 - For State Registrar	State of Maryla	-	artment of F			ene g. No. 006	05875
	Physici		1. Decedent's Name (First, Middle, Last)	lner				2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give s	treet and number)			r Location of Death	i Cis	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 1□	M 20 F 7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 18	Year) 9. Bir C, 1918 Ma	thplace (State or Foreign ountry)
	Maryland f ehow	tor	Usual Residence of Decedent 10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23s or 28s	Funeral Director	10e. Street and Number		onnell	10f. Zip Code	57	10	g. Citizen of What C	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hyglene. Department of Heelih and Mental Hyglene important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any figury or other traumatic event. The Medical Examinar must be notified at ance.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	I2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify: W	te, etc.
21215-0036	d within 72 ho giene. ir than "natui I'le Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+) 1 year	16a. Dece (Give Dir	dent's Usual Occup kind of work done DO NOT use retired ECLOT OI	during most of work Children	ing 1	6b. Kind of Business St. Agnes	Mndustry s Hospital
Maryland	ould be filed I Mental Hyguarked otheratic event,	To Be C		e W. Speake				e Crouch		
e, Mar	1 and 2 sh Heelth and In 27 le m		Roy Palmer / Hust 20a. Method of Disposition	oand	3801		Drive Ap	t.102 R	City or Town, State, andallstov	vn, MD 21133
Baltimore,	Pages tment of I tant: If It jury or of		1 □ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, cre preland	matory or other plac Cemetery	2/24	_	Baltimore,	
Ba	Departition Departition Superition Superitio		21. Signature of Funeral Service License	raminous	the !		nie Highwa	ay Balt:		ce, P.A. yland 21225
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P.O. Box 6	the death certific. y the attending pl ched for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
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Ħ	rsician: Th s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 24	TER/Outpatier	at 3□ DOA Oth	er: 4 Nursing Ho	1111	nce 6 Other (Spe	scribe)
Division of Vital	Attending Physician: The rideath. ector: After this certificate hiby the funeral director, page	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur Wor		28d. Describe how		oly)
DIX	To the Hospital or Attenwithin 24 hours after deating the Funeral Director: completely filled in by the		4 Homicide determined	28e. Place of Injury - At I building, etc. (Specifician: To the best of my kr	ify)			City or Town,		
	To the Hos within 24 h To the Fun completely	Medicai	(Check only one) 2 Medical Examin 29b. Signature and title of certifier	er: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	pinion, death occurr	ed at the time, da	te and place, and due	e to the cause(s)
1	4) con I dre	-		בה	1908		E 0 20	
	10		30. Name and address person who con	neus and	,	,	0 10 600	est Res	- 21	133
)tz	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	locale)				

			For State Registrar	State of Marylar	-	rtment of H		fental Hygie	ZUUh	05876
	Physici /Medio		1. Decedent's Name (First, Middle, Las	D. Pocklii	ngtor)		2. Date of Death Month	day 2 2000	3. Time of Death 2057 M
	Examir	er	4a. Fecility Name (If not institution, give University of M 5. Social Security Number 6. Se	laryland Ho	OSpital Jast birthday)	4b. City, Town, or Balt	MORE C	8. Date of Birth	4c. County of Deat	h hplace (State or Foreign
	Funeral Director		219-32-9581 10 Usual Residence of Decedent	ØM 2□F (69 Yrs.	Months Days	Hours Min.	(Month, Day, Ye	ar) MCO	ryland
	Marylar f show	tor	Maryland Baltimo		ity, Town or Loc Baltimo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the 3a or 28a	il Director	10e. Street and Number 2805 Louisiana	Avenue		10f. Zip Code	227	10g.	Citizen of What Co	untry?
980	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or teme 23a or 28a-f show event, the Medical Erection materials at mind the notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Opivorced	12. Was Decedent Ever in L Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
Maryland 21215-0036	d within 72 ho jiene. r than "natur the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th		(Give I	OO NOT use retired	during most of work	16b	Constru	ŕ
and	d be filed antal Hygi ced other c event, t	Be	17. Father's Name (First, Middle, Last) Aubre	y Pocklington				e (First, Middle, Maio		
Jary	ges 1 and 2 should be it of Health and Mental If item 27 is marked or or other traumatic ev	T ₀	19a. Informant's Name/Relationship (7. Myrtle Johnson /	Type, Print)	19b. Mailin	g Address (Street a	and Number or Rur	al Route Number, Ci	ty or Town, State, Z	Zip Code) and 21227
re, N	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition	20b.	Place of Dispos		1 1		Location - City or	
Baltimore,	iit. Page artment or ortant: If injury or		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licenses) La		Mem. Par				, Maryland
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30	/Medical Examiner		resulting in death)	Due to (or as a consec		77-10-11-				of monins
0,00	death certificate be executed e attending physicien and of for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect						
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Vita	Physicien: r this certifica ral director, I	Be	25. Was case referred to medical examiner? 1) Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 🍒	ÉR/Outpatient	2 DOA Othe	26. Place of Death			
Division of Vital Records,	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification; To	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun	4 Nursing Ho	me 5 Residence 28d. Describe how in		zify)
Divis	el or Atte	Sertific	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Speci	fy)			28f. Location (Street City or Town, St	tate)	
	To the Hospitel or within 24 hours after the Funeral Dir completely filled in its completely fil	edical (29a. Certifier (Check only one) 15 Certifying Phy 2 Medical Exam	vsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	Attendine	1	29c. License	17742	290.	Date signed (Month	1. Day, Year)
•	3		30. Name and address of person who co	completed cause of death (Item	m 23a) (Type, F	Print) R. H.	mino Mil) 21201		7, 4
- 24	Sta Registr	_	31. Date filed (Month, Day, Year) FEB 2 8 21	32. Registrar's Sign	ature	alls.				

•	,		1 - For State Registrar	State of Marylar		artment of H			ZUU	6	058	77
			1. Decedent's Name (First, Middle, Las				Journ	2. Date of Death	No.		3. Time o	of Death
	Physici /Medi		AUBREY	PITTMA	AN			Month FEBRUAR	Day 22	Year 2006	1:50	РМ
	Examir		4a. Facility Name (If not institution, give	, ,	I. I	4b. City, Town, or	Location of Deat	h	4c. County			
			NORTHWEST	HOSPIT	146	Randa11s				timor	e	
	Funeral Director		5. Social Security Number 6. Se 228–16–1741	7. Age (In yrs. 95	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day, Ye	ear)	Court		or Foreign
	_		Usual Residence of Decedent	- 95				Apr 18,	1910	Virg	Lnia	
	how	_	10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				10	Od. Inside C	City Limits
	Ba-1 e	cto	MD	В	altimor	:e					1₹ Yes	s 2 No
	vith th	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of V	What Count	ry?	
	eath v	era	4506 Fairview AVe		10	21216				SA		
"	fter d	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No		Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	pecify Yes or No- o Rican, etc.)		e - America k, White, e		
8	el', o	þ	3 ☐ Widowed 4 🌠 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2∏ No	Specify:		Specify	· b1	ack	
21215-0036	within 72 hours after death with the Maryland ene. then 'naturel', or iteme 23e or 28e-f ehow he Madical Exemirer must be notified at	Completed by	15. Decedent's Edu (Specify only highest grad		16a. Deced	ent's Usual Occupa kind of work done of	ition	161	. Kind of Bu	usiness/Ind	ustry	
2	hen.	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	O NOT use retired,)	King .				
	filed v Hygie Sthert	ပိ	12 17. Father's Name (First, Middle, Last)	2	te	acher	10 Markada Na	- (5: 14: 44: 14		ation	L	
Maryland	d be	o Be	Delaney Wise Pitt	man		:		ne (First, Middle, Mai		10)		
ary.	should nd Men marke umatic	٩	19a. Informant's Name/Relationship (T)		19b. Mailin	g Address (Street a		Bill Crocl gral Route Number, Ci		State Zin	Codel	
	and 2 eelth a n 27 le		Shirley Charles/d	aughter				Baltimore,		21216		
ore,	of He of He r item		20a. Method of Disposition		Place of Dispos				. Location -			
<u><u>ĕ</u></u>	Peges ment of I ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Terrioval from State	,,	atory or ouror pract	1	1				
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: If fram 27 le marked other then "naturel", or iteme 23e or 28a-1 ehow eny injury or other traumatic event. In Medical Examiner must be notified at once.		21. Signatu Funeral Service Licens	ade forecto	r St	Name and Address ate Anato ltimore,	s of Facility Omy Boar	d 655 W. B	altimo	ore S	treet	
			23a. Part1. Enter the disease or compl shock or heart failure. List only o	ications that caused the deat	th. Do not ente	r the mode of dying	MD 2120 g, such as cardiad	or respiratory arrest,			Approximat	
	Physician		Immediate Cause (Final disease or condition	GASTROIN	ITEST	TIN)AI	BI FF	DING			Interval Bet Onset and I	
	/Medical Examiner		resulting in death)	Due to (or as a conseq		7-0710	1001	-1.00				
	Examiner	_	Securatially list conditions, if any, leading to immediate	V								
	pe ist	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):							
	al-trar	xan	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					_		
8760,	ficate be executed physicien and s the burial-transit	dicai E			, , , , , , , , , , , , , , , , , , , ,							
	tificating phy as the	edic										30
Вох	at the death certifi by the ettending is stached for use as	Physician/Me	200. Tras decedent pregnant	3c. If yes, outcome of pregna 1□Live birth 2□Feta		129			23d. Date	e of deliven	Y	
E	ed fo	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of d		Ectopic pregnancy Other (specify)			Mor	oth D	ay 1	Year
0.0	that the	Phy	9 Unknown									
Š,	es t gne be o	þ	Part II. Other significant conditions con			derlying cause giver	n in Part I.	23e. Did tobaco				
Š	w require been sig should b	etec	V/102010	3 3/4-14	-			1 🗆 Yes		3 Probal	. /	Inknown
ě	0 - 0	Completed						24a. Was an autopsy	P	rior to comi	sy findings a pletion of ca	available ause of
	certificate he	ပို	25. Was case referred to medical	50		_		performed	No 1	eath? □Yes 2	No.	
	2 %	OB	examiner?	lospital:	ER/Outpatient	3□ DOA Other		th Check only one	a Clau			
0	g Phy ter thi	Ę.	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury	4 Nuising n	ome 5 Residence 28d. Describe how in				
Š	Attending ir death. ector: After by the funer	atio	1 Accident 5 ☐ Pending investigation	(MOHII, Day Feat)	Injury		es 2 🗆 No					
_	al or Attend s after death I Director: , d in by the f	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of fnjury - At ho building, etc. (Specify	ome, farm, stree	et, factory, office		28f. Location (Street City or Town, St	and Numbe	or Rural I	Route Num	ber,
	i o the Hospital of within 24 hours at To the Funeral D completely filled it	edicai	29a. Certifier 1 Certifying Physical Condition 1 Certifying Physical Cardinal Physical Cardinal Physical Cardinal Physical Cardinal Physical Cardinal Physical Physic	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death tion and/or inve	occurred at the time estigation, in my opi	e, date and place, nion, death occur	and due to the cause red at the time, date a	(s) and mar	ner as stat	ed. he cause(s)
;	withir To th comp	Me	29b. Signature and title of certifier			29c. License			Date signed			
			1	1000		DS	74353	<u> </u>	BRU	ARY	22	2006
			30. Name and address of person who co	mpleted cause of death (Item	1 23a) (Type, P	rint) Mir	CEA TO	DOR	1001	. 1		
			NOTHWEST HO			D COURT	ROAD	RANDALLS	10W1	NM	15 C	133
	Stat Registra		31. Date filed (Month, Day, Year) FFR 2. 8. 2006	32. Registrar's Signat	ture Angul	ال					100000000000000000000000000000000000000	

			1 - For State Registrar		State of	of Mai	rylan		artmen <i>rtificat</i>			and M	lental Hy	giene	1000	05878
	Physici	an	1. Decedent's Name (First, Mid										2. Date of De. Month	Day	Year	3. Time of Death
	/Medic		Jennie Marie										Month 02	05	2006	09:20p ^M
ļ.	Examin	er	4a. Fecility Name (If not instituti			imber)					Location o			4c.	Montgo	
			8560 2nd Ave 5. Social Security Number	6. Sex	1704	7 400	(In vre	last birthday	If Under		r Spr		8 Date of Bird	ıb.		
	Funeral Director		093-46-0226		M 25014F	5	2	Yrs.	Months		Hours	Min.	8. Date of Bird (Month, Da 01-17-			othplace (State or Foreign Country)
			Usual Residence of Decedent	<u> </u>							1,		01-17-	-190	+ 1 1	derto kico
	yland how		10a. State 10b. Coun	y			10c. Cit	y, Town or L	ocation							10d. Inside City Limits
	e-f-	ctor	MD Mon	gome	ry		Si	ilver	Sprin	g						1⊠Yes 2□No
	or 28	Director	10e. Street and Number						10f. Zip	Code				10g. Cit	izen of What C	Country?
	23e	ral	8560 2nd Ave	Apt	1704						20910				JSA	
	er der	nue	11. Marital Status		2. Was Dec Armed F	orces?		S. 13.	Was Dece If Yes, spe	dent of H cify Cuba	ispanic Ori in, Mexicar	gin? (Sp.	ecify Yes or No Rican, etc.)		 Race - Am Black, Wh 	
36	s afte	by Funeral	Mever Married 2 Married 3 Widowed 4 Divorce		1 □Yes If Yes, G Year or t	ive)		1 🛣 Yes	2□ No	Specify:	Pue	rto Ric	an	Specify: W	Mite
응	within 72 hours after deeth with the Maryland ene. Than "naturel", or iteme 23e or 28e-f ehow he Medical Examinar must ke nutilied at	edt	15. Decede		17,54	Za(85.		16a. Dece	dent's Usu	al Occun	ation			16b. K	nd of Busines	s/industry
57	n "na	Completed	(Specify only high	est grade	completed,		`	(Give	kind of wo	rk done i se retired	during mos d)	t of work	ing	100111		a
72	i with	mo	Elementary/Secondary (0-12)		College (1-40r5+)	Tea	cher'	s Ai	de]	Educati	on
ğ	othe	0	17. Father's Name (First, Middle	, Last)									(First, Middle,		Sumame)	
<u>a</u>	Menta Menta rked rtc e	To B	Felix Plaza								Ma	tild	le Alvar	ado		
Maryland 21215-0036	and l		19a. Informant's Name/Relation	nship <i>(Typ</i>	e, Print)			1					al Route Numbe	-		Zip Code)
≥ ``	and and m 27		Sonia Plaza/	siste	r		1	_					pring N			
ore	of H If ite		20a. Method of Disposition 1 ☐ Burial 2 🖫 Cremation	3 □Re	moval from	State		lace of Disp emetery, cre					Date		ocation - City o	
Ē	Pag ment tent: jury		4 Donation 5 Other	Specify)			Cl	nesape					08-200		Beltsvi	Tie WD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mentel Hygiene. Department of Health and Mentel Hygiene. Instruction: If Items 23 a or 28e-f ehow any injury or other treumatic event, the Medical Examinar must be nutitied at angone.		21. Signature of Funeral Service	e Licensee	_	moli		2	2. Name ar Rapp	Fun	ss of Facili eral	& Cr	emation	1 Set	rvice	
			23a. Part1. Enter the disease,	or complic				n. Do not en					r Sprin		20910	Approximate
			shock, or heart failure. Li Immediate Cause (Final	st only one	cause on	each line Lung).			,						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	_ a.	_		_	uence of):								10 months
	Examiner					(0. 00 0	99.1004	2000 0.7.								
		ē	Sequentially list conditions,	Ь.	Due to	(or as a	conseq	uence of):								
	cuted nd ransii	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.												
760,	e exe ien a uriai-	Ä	resulting in death) Last		Due to	(or as a	conseq	uence of):								
876	Physician: The law requires that the death certificate be executed this certificate hes been signed by the attending physicien and ral director, page 2 should be detached for use es the burial-transit	dlcal		d.												
9 ×	eath certific attending p I for use es t	Physiclan/Med	IF FEMALE:	23	c. If yes, ou	itcome of	foreana	incv							00d Data of d	
.O. Box	atten for u	re la	23b. Was decedent pregnant in the past 12 months?		1 Live	birth 2 nant at ti	Feta	Ideath 3	☐Ectopic p		,				23d. Date of de Month	Day Year
o.	the d y the iched	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unkr				3 0 11 10 1 10	,						
σ.	res that the de signed by the a be detached f	by Pt	Part II. Other significant condi	tions cont	nbuting to	death but	not res	ulting in the I	ınderlying o	ause giv	en in Part I		23e. Did t	obacco i	ise contribute	to the cause of death?
Records,	n sign	D D											10	Yes 2	□No 3□F	Probably 4 DUnknown
ပ္ပ	sw requires s been si should I	Set											24a. Was		24b. Were a	autopsy findings available
æ	The la	Completed											autor perfo	rmed?	death?	
<u> </u>	ian: rtifica stor. p	Bec	25. Was case referred to medic	al							26. Place	of Deat	h (Check only o			
>	nysic nis ce I direc	To	examiner? 1 ☐ Yes 2 ☐ No	Ho	spital: 1 🗆	Inpatient	2 🗆	ER/Outpatie	nt 3 🗆 D0	Oth Oth	er: 4□Nu	rsing Ho	me 5⊠Resi	dence	6 □Other (Sp	ecify)
0	ng Pi		27. Manner of Death 1√⊒Natural 5 ☐ Pend	lina	28a. Date (Mor	of Injury	Year)	28b. Time of Injury	of 2	28c. Injun Wor	y at k?		28d. Describe l	how inju	y occurred	
<u>S</u>	Attending r death.	catl		tigation					М		Yes 2	No				
Division of Vital	or At after d Direct In by	Certification:		mined	28e. Plac build	e of Injur ling, etc.	y - At ho (Specif	ome, farm, si y)	reet, factor	y, office			28f. Location (. City or To			Rural Route Number,
	To the Hospitel or Attending Physician: The law within 24 hours after death. Vithe Funeral Director: Affer this certificate hes completely filled in by the funeral director, page 2		29a. Certifier 1 Certify	ing Physi	cian: To th	e best of	my kno	wledge, dea	th occurred	at the tin	ne, date ar	nd place,	and due to the	cause(s	and manner	as stated.
	he Ho n 24 h he Fu pletely	Medical	(Check only 2 Medic	I Examine	er: On the l	nasis of e	xamına ed.	tion and/or in	vestigation	i, in my o	pinion, dea	ith occur	ed at the time,	date and	d place, and du	ue to the cause(s)
	To t withi To ti	Σ	29b. Signature and title digertif	ier /	7/	2	00	,	29	c. Licens	e number			29d. Da	te signed (Moi	nth. Day, Year)
) (//	n	-00	se	×4			D01	.01				02-07-2	2006
	1		30. Name and address of person								.1	ron T	74 2220	5		
	,		Thomas Butle		1630	N. G	eor	ge Mas	on Di	. A1	Ting	LOII '	VA ZZZU			
9.0	Sta Registr		FEB 2			्रिक्षित	s Sa	Y. Age	seles							

			For Stata Registrar	State of M	-	epartment of H Certificate of I		lental Hygiei Reg.	21111	5 05879
	Physici		Decedent's Name (First, Middle Joan Dorot		1			2. Date of Death Month February	25. 20	3. Time of Death 7: 20P M
5	/Medio		4a. Facility Name (If not institution,			4b. City, Town, or	r Location of Death		4c. County of D	
			206 Delig				erstown		Ba1t:	
	Funeral Director		084-26-7974	6. Sex 7. A	ge (In yrs. last birtho	Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye July 7, 1	9. 932 Ne	Birthplace (State or Foreign Country) BW York
land	M II		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
Man	- 9	ţ	MD Balti	more	Reis	terstown				1 ☐ Yes XXNo
th the	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What	Country?
ath w.	23a	182	206 Delig				1136		U.S.	Α.
17275-0036 within 72 hours after death with the Maryland	nd Mental Hygiene. marked other then "naturel", or iteme 23a or 28a-f ehow imatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie XXVidowed 4 Divorced	12. Was Deceden Armed Forces ed 1 ☐ Yes X/2 If Yes, Give Year or Dates:	No	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes XX No		ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc. White
3 2	age age	ted	15. Decedent	s Education	16a. D	ecedent's Usual Occup	ation	16b	. Kind of Busine	
7 oid:	A Land	ple	(Specify only highest Elementary/Secondary (0-12)	t grade completed) College (1-4or	(5+)	Give kind of work done of the DO NOT use retired	•	ring	Mun	icipa1
Maryland 21215-0036	ygien t, th	Completed	12		De	puty Town			Gover	nment
	Mental Hygiene. Larked other then Latic event, the M	Be	17. Father's Name (First, Middle, L	in the second				e (First, Middle, Maid	ien Sumame)	
aryla should	of Health and Ment fitem 27 ie marked r other traumatic	L C	John Galuna		405.4	4-11		Groves	.	7.011
Mai d 2 st	th and 7 ie m traum	7.8	19a. Informant's Name/Relationsh Suzanne Slona			Mailing Address <i>(Street)</i>				
a 🖺	Health tem 27 other tr		20a. Method of Disposition	incz / Daug	20b. Place of D	isposition (Name of			. Location - City	
more,	it: if i		1 ☐ Burial 2 X☐X remation 4 ☐ Donation 5 ☐ Other (Sp		9	crematory or other place trematory	1	27/06	231+ima	NTO MTO
	Dependent of Pimportant: if ite eny injury or of once.		21. Signature of up al Swice L		110010					chapel P.A.
ň	9 1 9		theprol	Tunu		11605 Rei:	stersto	wn Rd, Ow	ings M	111s, MD2111
8760,	hysician and hysician and purial-transit sthe burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	s a consequence of) s a consequence of) s a consequence of)		ve Pul	nonery	Disec	Approximate Interval Between Onset and Death
P.O. BOX 6	/ the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		e of pregnancy 2 Fetal death at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	1		23d. Date of Month	delivery Day Year
rds, r.	been signed by the s should be detached	ğ	Part II. Other significant condition Dement		but not resulting in t	ne underlying cause giv	en in Part I.	23e. Did tobacc	_	e to the cause of death? Probably 4 Unknown
Division of Vital Records, for Attending Physician: The law requires t	leath. Lor: After this certificate hes bee the funeral director, page 2 sho	Completed						24a. Was an autopsy performed	? prior	
VISION OF VITAL	certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		! Ош	00	th (Check only one)		
O A	this or	<u>۲</u>	1 Yes 2 No	28a. Date of In		atient 3 DOA Oth	4 Li Nursing no	ome SPesidence		Specify)
	h. After funer	盲	Natural 5 Pending	g (Month, D	ay Year) Inju	ry Wor	k? Yes 2 □ No	250. Describe now i	njury occurred	
/ISI/	efter death Director: / in by the f	lca	3 ☐ Suicide 6 ☐ Could n	ot be 290 Place of It	njury - At home, farm	, street, factory, office		28f. Location (Stree	and Number o	r Rural Route Number,
	i Dire	Certification:	4 Homicide determi	building,	etc. (Specify)	,		City or Town, S	tate)	
J Jetiosoftett	within 24 hours effer d To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying	g Physician: To the bes Examiner: On the basis and manners	of examination and/	death occurred at the tir or investigation, in my o	me, date and place,	and due to the cause red at the time, date	e(s) and manne and place, and	r as stated. due to the cause(s)
Ė	within 7 To the comple	ž	29b. Signature and title of certifier	WICK	MELLISA	29c. Licens				onth, Day, Year)
	0		•		NDING A	1180	4776	2 2	2/27/	6
10) · ·		2352 yor	To completed cause of	death (Item 23a) (T	(pe. Print)	30 NIC	KMellis		
	Sta Registi		31. Date filed (Month, Day, Year) FEB 2	32. Jegis	trar's Signature	Cook				

State

Registrar

31. Date filed (Month, Day, Year)

FEB

8 2006

32. Registrar's Signature

			For State		f Maryland	/ Depa		t of H	lealth a	and N	Mental Hyg	iene	ns.	05881
			Registrar 1. Decedent's Name (First, Middle, I	41		Ce	runcau	9 01 1	Jeani		2. Date of Deal	eg. No:	a see party	3. Time of Death
	Physici	an			•						Month		Year	3:00 AM
	/Medic			Ridge,			44 03	-		4.0		·	06	3.0-7
1	Examin	er	4a. Facility Name (If not institution, g	rve street and nu	mber)		4b. City,	i own, or	Location of	of Death			nty of Death	
			1270 Buckhorn 5. Social Security Number 6	Road	7. Age (In yrs. la:	et hirthdayl	If Linder	Şyk	ASW	lllc	8. Date of Birth		arro.	l 1 blace (State or Foreign htty) MD
	Funeral		161-32-2224	157M 2□F	7. Age (III yrs. Ia:	Yrs.	Months	Days	Hours	Min.	Apr 1,	1939	Cour	ntry) MD
	Director		Usual Residence of Decedent								API I,	1000		PID
	ow .		10a. State 10b. County		10c. City,	Town or Lo	ocation						1	10d. Inside City Limits
	Man,	ţō	MD Carr	011	S	ykes	ville	3						1 Yes 2 No
	r 28s	irec	10e. Street and Number	<u> </u>			10f. Zip	Code			1	0g. Citizen	of What Cour	ntry?
	30 o	<u>=</u>	1270 Buckhorn	Road				2	21784				USA	
	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show the Madigal Exempler must be notified at	Funeral Director	11, Marital Status		edent Ever in U.S.	. 13.	Was Deced	ent of H	ispanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)		ace - Americ	
9	after or Its	Ē	1 Never Married 2 Married	Armed Fo	2 No	1				i, rueito	rican, etc.)		lack, White,	
8	ral',	b	3 Widowed 4 Divorced	Year or D	ates:		1 Yes	X NO	Specify:			Spe	cmy: Wr	nite
က်	72 honatu	Completed	15. Decedent's (Specify only highest	Education		(Give	dent's Usua kind of wor	k done o	durina mas	t of work	ana	16b. Kind <i>a</i> l	Business/In	dustry
7	things and the	npl	Elementary/Secondary (0-12)	College (life.	DO NOT us	e retired	1)					
7	filed w Hygier other th	S		5_			Plum	ber	•		(E)	Cons	truct	ion
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at	Depart Depart Import any Inj ance.		21. Signature of Funeral Service Lic	ensee		F	ATCH	TAdd F	UNER	AL	HOME &	CHAP	EL (P	Box 195)
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			23a. Part1. Enter the disease, or co shock, or heart failure. List or	ly one cause on i	each line.				-	cardiac	or respiratory arm	est,		Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition		Respi	rator	y. A	116	5 T				Y	Onset and Death Ninvie 5
	/Medical		resulting in death)	Due to	(or as a conseque (or as a conseque (or as a conseque	ence of):	. 4	000	()					- 100
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89 x	The law requires that the death certifica ste hes been signed by the ettending ph page 2 should be detached for use as th	by Physician/Med	IF FEMALE:	00. 1/										
Вох	ath co	an/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live I	tcome of pregnand pirth 2 Fetal o	death 3(⊒Ectopic pr		,				Date of delive Month	ery Day Year
<u>o</u>	the e	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Prega 9⊟Unkn	nant at time of dea lown	ath 5L	Other (sp	ecity)						•
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	ires tha signed d be del	þ	Part II. Other significant condition	s contributing to o	eath but not resun	ung m me c	andenyang c	ause givi	BHIIIFOULI	•		es 2 No		pably 4 □Unknown
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Division of	ng P Kter t	i o	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Mon	of Injury 2 oth, Day Year) 2	28b. Time o Injury		8c. Injun Worl			28d. Describe ho	ow injury occ	urred	
Si Si	Attending r death. sector: Atter by the fune	cati	2 ☐ Accident investiga	ho -			М		Yes 2	No				
Ξ̈	ter d Iract	Certification;	3 Suicide 6 Could no 4 Homicide determin	288. Place	e of Injury - At hom ling, etc. (Specify)	ne, farm, st	reet, factory	, office			28f. Location (Si City or Town		mber or Rura	al Route Number,
Ω	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral													
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	wit To		29b. Signature and title of contriber	1	100	o '	290		e number			_	ned (Month,	
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	Y		30. Name and address of person w	Askin	gton	1-ter	Print) 1 Nts		N	امه	s menste	r., r	no e	1187
	Sta Regist		31. Date filed (Month, Day, Year) FEB 2 8	2006	Registrar's Signatu	are fo	ens							

AMENDED BY COURT ORDER Please Type or F Amend item#4a,10e,19a,per#D,FH, (State of The or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MD. FH. (BS3.37/16 TT

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#23a, per COURT ORDER, G985, 3/17/2017, WS

Certificate of Death 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 21 Physician Ralph Leroy Redden 4:44 P.M February 2006 /Medical 4a. Facility Name (If not institution, give street and number)
2765 Nortin Road 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | North | Dec. 21, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖫 F 59 212 44 3094 Director 1946 Mary1and Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Maryland Baltimore Director Baltimore 10e. Street and NurNorfen 10f. Zip Code 10g. Citizen of What Country? or Itams 23a or 2765 Norfin Road U.S. 21227 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item eny injury or other traumatic event. 1 XYes 2 No 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No MYes, Give Viet Nam Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify onfy highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shipping Manager Automobile 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Paul Redden Edith Mulligan 19b. Mailing Nortes (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2765 Nortes Road Baltimore, Maryland 21227 19a. Informant's Name/Relationship (Type, Print) Brenda Lee Redden / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State Bayview Crematory 2/27/2006 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Non-Small Cell Lung Cancer Approximate Interval Between Onset and Death Immediate Cause (Final CANCE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the attending physicien and the for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No be detached 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes 2No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ۵ 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation Injury death. 1 Yes 2 No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4108000 10-41 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ritchie Wwy Suite 20 reffren pulglein 32. Registrar's Signature 31. Date filed (Month, Day, Year) State pode Registrar

ORIGINAL

			1 - State Registrar		Ce	rtificate of		Reg	ene 0 0 6	05883
	Physici /Medic		Decedent's Name (First, Middle, Last)	WILLIAM	T. ROBE	RSON, SF			^{Day} 26, 2006	
	Examir	er	4a. Facility Name (If not institution, give s STELLA MARIS HO	SPICE		1	or Location of Death	h	4c. County of Deat BALTI	
	Funeral Director		703 10 3243	7. Age XM 2□F	e (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	2/21/1917 _{3. Birt} (ea <i>r</i>) 177 N	hplace (State or Foreignatry) IARYLAND
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limit
	e Man	ctor	MD. BALTIM	ORE		LUT	HERVILLE			1 ☐ Yes 2 💢 💢
	death with the Maryland me 23a or 28a-f ehow rmat be rictified at	al Dire	313 FELTON ROAD			10f. Zip Code 21 0	93	10g	U.S.A.	
920	iges 1 end 2 should be filed within 72 hours atter death with the Marylar NI of Heelth and Mental Hygiene. If Item 27 is marked other than "natural", or Iteme 23a or 28a-1 ehow or other treumatic event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 WWidowed 4 Divorced	12. Was Decedent I Armed Forces? 1/2/Yes 2 \(\subseteq \) If Yes, Give Year or Dates:	lo	Was Decedent of H If Yes, specify Cub 1 ☐ Yes XX No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: W	
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Maryland 21215-0036	should be fill not Mental H; marked oth	To Be			ROBERSON		FLORI		RECKER	
	end 2 sh seith end n 27 is m		19a. Informant's Name/Relationship (Ty) WILLIAM T.ROBERSON	•				Iral Route Number, C NKTON, MARY	-	
ore,	les 1 er of Hee if Item or other		20a. Method of Disposition 1 □ Burial 2XX Cremation 3 □R	emoval from State	20b. Place of Dispo	osition (Name of	cel	Date 20	c. Location - City or	Town, State
Baltimore,	pernitt. Pages Department of i Importent: if it any injury or o		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			SERVICE C 2. Name and Addre		01-2006 10		LAND, 2120
a B	Dep Imp		P. H. Kun		G.RUTH) RÎ	UCK TOWSO	N FUNERAL	. HOME, INC	1050 YO TOWSON,	RK ROAD MD.21204
68760,	By physicien as the business are the business as the business are the business and the business are the business ar	al Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, seamed to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as to	GE RENAL D a consequence of): a consequence of):	ISEASE				Interval Between Onset and Death
.O. Box 687	The law requires that the death certificate be executed the hes been signed by the ettending physicien end tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnanc	y		23d. Date of deli Month	very Day Year
٥.	w requires that been signed by should be deta	ρ	Part II. Other significant conditions con	tributing to death bu	it not resulting in the u	nderlying cause giv	en in Part I.		cco use contribute to	the cause of death?
I Records,		Completed				· · · · · · · · · · · · · · · · · · ·		24a. Was an autopsy performe	d? death?	topsy findings available completion of cause of
Vital	yelclen: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	ospital:				th Check only one		
Division of	ding Ph h. After th funeral	ation: To	1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		f 28c. Injui	4 Nursing H	ome 5 ☐ Residence 28d. Describe how		HOSPICE
Divis	5 # <u>5</u> 5	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	ry - At home, farm, str :. (Specify)	reet, factory, office	Appended to	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	HO F L P	Medical (29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of ner: On the basis of and manner sta	of my knowledge, deatle examination and/or in ted.	h occurred at the till vestigation, in my o	me, date and place ppinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier			29c. Licens	se number		Date signed (Month	
			30. Name and address of person who co	moleted cause of de	eath (Item 22a) (Time	Print)	13725	F.	EBRUARY 2	27, 2006
1	2+1		DR. TARIQ MAHMOOI	2300 DI	JLANEY VAL	·	TIMONIUM	, MD 21093	3	
	Sta	10	31. Date filed (Month, Day, Year)	32. Registra	r's Signature					·

DHMH 17 Rev 1/2001

State

Registrar

FEB 2 8 2006

FEBRUARY 26, 2006 1:25 p.m.

WILLIAM ROBERSON

State of Maryland / Department of Health and Mental Hygien 05886 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day REDMOND Year **Physician** LINDA 09.20 Pm TEBRUARY 21 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WOMEN MARILAND CORECGIONAL INSTITUTION FOR JESSUF HOWARD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1□ M 212 F Birthplace (State or Foreign Country) Days Hours 53 212-56-7879 MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NA 1 Yes 2 No Baltimore **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3823 Victoria Ave 21244 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1

✓ Never Married 2 Married 1 ☐ Yes ¾☐ No Specify: Completed by Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Printer Weaverly Press 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roosevelt Redmond Alice Stubbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Vanessa Green-Sister</u> 3823 Victoria Ave, Baltimore, Md 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 D Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion 2/28/06 Baltimore, Md 22. Name and Address of Facility
March F/F West 21. Signature of Funa al Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 Part1. Entar the disease, or complications and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ENDSTACE Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 ☐ Yes 2 ☑ No 1 🗆 Yes 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3□ DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number mis D45149 21 2006 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) ONABATO Correctional Institution for Women Jessup MD 20144 Marriand istrar's Signature 31. Date filed (Monto, Day, Year) 32. Reg

State Registrar

Funeral

Director

7 is marked other than "natural", or items 23a or 28e-f shor traumatic event, the Medical Examinar must be notified at

permit. Pages 1 end 2 should be file Deportment of Health end Mentel Hy Important: if item 27 is marked other any injury or other traumatic event

Physician

Examiner

/Medical

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After

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within 24 hours efter dear To the Funerel Director completely filled in by the

Maryland 21215-0020

Baltimore,

Division of Vital Records, P.O. Box 68760,

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DHMH 17 Rev 1/2001

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			1 - For State Registrar	State of	Maryland /	-	rtmen tificate			and M		jiene leg. No.	006	0:	886
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	Physici /Medic		Dovie Lucille	Scruggs							Februai	y 25	5, 200	6 1	1:00 A M
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40		(c) 5-78	1000 Franklin A				Esse		IS I to do a	0411			altimo		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖫 F	7. Age (In yrs. last b	inthday) Yrs.	If Under Months	Days	If Under	Min.	8. Date of Birth (Month, Day	(Year)	9.1	Birthplace Country)	(State or Foreign
- E	Director		251-28-9951 Usual Residence of Decedent		88						June 8	, 191	Sc	outh (Carolina
land	MO TE		10a. State 10b. County		10c. City, Tov	wn or Lo	cation							10d. lr	nside City Limits
Man	fied a	ţō	Maryland Baltin	ore	Esse	X								1	☐Yes 🏋 No
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h wit	23a o	D D	1000 Franklin A	venue. Apt	819		212	21				U.S.	Α.		
daa	me i	ner	11. Marital Status		dent Ever in U.S.	13. V	Vas Deced	ent of His	panic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	1	4. Race - A		ndian,
e de la	or ltu	J.	1 Never Married 2 Marr		2 ⊠ No		Yes 2		Specify:	1, 7 40110	riicari, etc.,		Black, W Specify:	mile, etc.	
Sinot	Iral,	d b	3 ☑ Widowed 4 ☐ Divorced	Year or Da	tes:			120	ороолу.					White	
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C Z I Z I 3-0030 filed within 72 hours after death with the Maryland	than	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	stod		e reurea)				Balt	. Co	s. Sch	hools
	Hygin ther ant,		17. Father's Name (First, Middle,	Last)	J G G.				18. Mothe	r's Name	e (First, Middle,				
2 6	sed o	To Be	Junie Peeler						Allie				•		
should be	mari mati	F	19a. Informant's Name/Relations	nip (Type, Print)	19	b. Mailin	g Address	-			al Route Numbe	r, City or	Town, State	e, Zip Code	(e)
M 2	if Haalth and Mantal Hygiana. Itam 27 Is marked other than "natural", or Itama 23s or 28s-1 show other traumatic avent, The Madical Examiner must be notified at		Clyde Scruggs (Son)	2.	203	Hawth	orne	Road	d, Ba	altimore	e, Ma	rylar	nd 21:	220
ָר ב בַּ	Department of Health a Important: If Item 27 Is any injury or other tra		20a. Method of Disposition		20b. Place	of Dispos	sition (Nan	ne of			Date	20c. Loc	ation - City	or Town, S	State
Dailling	nt: If		1 Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S							arch	2,200€	Balt	imore	e, Mai	ryland
	partm ports y inju		21, Signature of Funeral Cervice	icensee		22	. Name an	d Address	of Facilit	Acki	Funera.	Luca	00 D	7\	
0 8	Dapa Impo	(766		_	1	407 C	ld E	aste	rn A	venue, l	Sse	k, Mar	ylano	d 21221
14			23a. Part1. Inler the disease, or show, or heart failure. List	complications that ca	used the death. Do	not ente	er the mode	of dying	, such as	cardiac o	or respiratory ari	est,		App	roximate rval 8etween
PI	nysician		tmmediate Cause (Finat disease or condition	AS	CVD									Ons	et and Death
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acute	and trans	Examiner	that initiated events resulting in death) Last	c											·
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y diji	attanding pr	Me	IF FEMALE;	23c If was outc	ome of pregnancy										
ath c	attan for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th 2 Fetal deat		Ectopic pro					23	3d. Date of Month	Day	Year
) ed	tha chad	hysiclan/Med	1 Yes 2 No 9 Unknown	9□ Unkno		3	Cilibi (Spi	9Ciiy)							
that i	signad by tha attandin I ba datachad for usa	•	Part II. Other significant condition	ns contributing to de	ath but not repulting	in the un	iderlying ca	use give	n in Part I.		23e. Did to	bacco us	e, contribute	to the car	use of death?
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<u> </u>	ificati or, pa	ပိ	25. Was case referred to medical	111111111111111111111111111111111111111					OF Diago	of Dooth	1 Tes	No No	1 🗆 Y	'es 2 🗆	No
/sicie	s cart	0	examiner?	Hospital:	patient 2 EP/O	utnatient	3 □ DO	Other	-	rsing Ho			Other (S	(nacyfy)	
2 ਵੁ	erthis eraldı	i i	27 Manner of Death	28a. Date of	tnjury 28b.	Time of		Bc. Injury Work			28d. Describe h			pochy	
	ath. r: Aft	atlo	Natural 5 Pendin 2 Accident investig	9	, Day Year)	Injury	М		/ es 2 🗆 l	No					
Atta	acto by th	ertification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place	of Injury - At home, f g, etc. (Specify)	arm, stre	eet, factory	office			28f. Location (S City or Tow		Number or	Rural Rou	ite Number,
2 5	s afta	Cer			g, stc. (opeany)						Only of 10W	n, Olale)			
To both the Hospital or Attanding Physician: The law requires that the death cartific	within 24 hours aftar death. To the Funaral Director: Aftar this cartific complataly fillad in by tha funaral director,	edical	29a. Certifier Certifyin (Check only 2 Medical	g Physician: To the l Examiner: On the ba	pest of my knowledg	ge, death	occurred a	at the time	e, date an	d place,	and due to the c	ause(s) a	and manner	as stated.	cause(e)
the H	the F	ledi	one)	and mann	er stated.	110011111				ur occurr					
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	70 m		DR. DAV2D Got 31. Date filed (Month Day, Year)		gistrar's Signature		16.001	c/ 5	1.	JACI	ro, MO		418	57	2,300
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06 - 1251Amend item#1,pen/E,3852,2/28/06 IT State of Maryland / Department of Health and Mental Hygiene B.K.S DORRINE SMITH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Dorine Smith 18, 2006 FEB 3:43 P /Medical 4b. City, Town, or Location of Death BALTIMORE CITY 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 2021 BRADDISH AVENUE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09-04-1938 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 M 2 F 219-32-8104 Yrs 67 Maryland **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State I show if Heelth and Mental Hygiene. Item 27 ie marked other than "natural", or Items 23a or 28a-1 ehov other treumatic avent, the Medical Examiner must be notified at 1 X Yes 2 No Directo Baltimore MD NA 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21216 USA 2021 Braddish Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Laborer Maryland Glass 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Eleanor Staton Fred D. Smith ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 Coventry Street Baltimore, MD 21229 Doris Clay/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5= 5 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. 4 □ Donation 5 □ Other (Specify) Arbutus Memorial Park 02-28-06 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 10 Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician force injuries and disease or condition resulting in death) a. Blunt /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ettending physicien and for use es the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 3 ☐ Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) signed by the e 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ed bluods 1 ☐ Yes 2 X No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of eath?

1 Yes 2 No s certificete hes b director, page 2 s autopsy performed 1 Yes 2 🗆 No director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE TXYes 2 □ No ٩ 2 ER/Outpatient 3 DOA within 24 hours after deeth.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury Found or Attending 5 Pending investigation 1 Natural subject assaulted 1> W 1 Yes 2 No 2:36 2 Accident Feb 18, 2006 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 2021 Breadish Ave, Buihmere Ha 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Fo the Hospital To Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

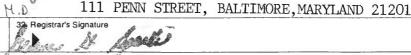
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E FEB. 19, 2006 My who completed cause of death (Item 23a) (Type, Print)

State Registrar

FFB 2 8 2006

Tasha Z Greenberg

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician 4734 LARY 24, 2006 81 00AM SHIRLEY STEWHRT /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Year If Under 24 Hrs. WASHINGTON 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Sex 1 M 2 F **Funeral** Days Hours Yrs. Director 459.48.1798 73 JAN 20. TEXAS Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or itsms 23a or 28a-f show traumatic svent, the Madical Examinar must be notified at traumatic svent, the Madical Examinar must be notified at 1∏Yes 2∏No **XX** Director TX TARRANT FORT WORTH 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4952 ROYAL DRIVE 76116 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2□ No **XX** Baltimore, Maryland 21215-003 þ 3 Vidowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) 12 WAREHOUSE SUPERVISOR **AAFES** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DAVID McCABE MERCER CECILIA CHRISTINA NOVAK 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Inportant: If Item 27 is read any injury or other ALDEN STEWART SON 4952 ROYAL DR FORT WORTH, TX 76116 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3XX removal from State 4 Donation 5 Other (Specify) MEMORY GARDENS 3.1.2006 WEATHERFORD, TX 21. Signatur Got Juneral Service Licens 22. Name and Address of Facil GREGORY FINK FUNERAL HOME, P.A. M01148 426 CRAIN HWY SW GLEN BURNIE, 23a. Part1. shock Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ACUTE MYOCALO, AC /Medical Due to (or as a consequence of): Examiner FATHL cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physicien and detached for use as the burial-transit certificate be execu Due to (or as a consequence of) 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation **Diractor**: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number FEBURAL 24, 2006 10055703 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 HOSPITAL OF GEN BURNE MO 21061 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 8 2006 Registrar

		1 - For State Registrar	State of Maryland / Do	epartment of Hea Certificate of De			ene 2006	05889
Physici /Medio		1. Decedent's Name (First, Middle, Last) Betty Evora Smith				2. Date of Death Month		ear 910 P
Examir		4a. Facility Name (If not institution, give s Citizens Care & Re 5. Social Security Number 6. Sex	ehab Center 7. Age (In yrs. last birth		k	8. Date of Birth (Month, Day,)	4c. County of	Death
Director		Usual Residence of Decedent	M 2 F 81 Y	'S.		April 30		Maryland
ne Maryla 8a-f ehov Allijed al	ector	Maryland Frederic	ck Frede:	rick				10d. Inside City Limit
h with th	al Dire	1900 Rosemont Aver	nue	10f. Zip Code 21702		100	g. Citizen of Wh	at Country? States
Joo urs after deal il', or Items?	by Funeral Director		12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Speciexican, Puerto Poecify:	city Yes or No- lican, etc.)	14. Race -	American Indian, White, etc.
DESITIMOTE, INTERVIBING Z Z 23-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Model Examitrational be mailible at ance.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation 16a. [completed) (College (1-4or 5+)	eccedent's Usual Occupation Give kind of work done during ife. DO NOT use retired)	g most of workin	g	6b. Kind of Busin	
DO A be filed v tal Hygie d other i	Be Co	17. Father's Name (First, Middle, Last)	Wa			(First, Middle, Ma	Food Se: aiden Sumame)	rvice
INATYIANO IN 2 Should be file Ith and Mental Hy 27 Is marked oth traumatic event	To	Joseph Schroyer 19a. Informant's Name/Relationship (Ty)	pe, Print) 19b. I	Aziling Address (Street and I	nnabe11e Number or Rural		City or Town, St.	ate, Zip Code)
Ore, IVIS		Shirley Price / Da 20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ R	20b. Place of E cemetery,	Walter Mar Disposition (Name of crematory or other place)	tz Rd. Feb.			1702 ty or Town, State
Dallimore, permit. Pages 1 a Department of Her Important: If item any injury or othe once.		'4 ☐ Donation .5 ☐ Other (Specify) 21. Signature of Funeral Service License	Resthav	en Crematory 22. Name and Address of Resthaven Fun	Facility neral Se			k, Maryland
Itigate be executed /Medical Examiner bhysician and Examiner is the burial-transit	edical Examiner	23a. Part Enter the disease, or complishock, or heart failure. List or an immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	tić Carlin	Vascula) dDes	na .	Interval Between Onset and Death
the death certiful the attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnancy 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of Month	
law requires that as been signed b	by	Part II. Other significant conditions con	tributing to death but not resulting in t	he underlying cause given in	Part I.	23e. Did toba 1 □ Yes	1.4	ute to the cause of death?
	Completed					24a. Was an autopsy performe	prio	re autopsy findings available to completion of cause of ath? I Yes 2 100
ding Ph	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 Yo 27. Manner of Dilath 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 ER/Outp 28a. Date of Injury (Month, Day Year) 28b. Tir	atient 3 DOA Other: 4	Nursing Hom	(Check only 6ne) e 5 TResiden. 3d. Describe how		(Specify)
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the Hospit in 24 hour the Funer ipletely fills	Medical (one)	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the time, do or investigation, in my opinion	ate and place, ar n, death occurred	nd due to the cau d at the time, date	se(s) and mann a and place, and	er as stated. d due to the cause(s)
with To 1	2	29b. Signature and title of certifier	Paymon	29c. License nur	1397	/ 290	1. Date signed (I	Month, Day, Year)
3		Robertor 9	mplated gause of death (Item 23a) (T	ype, Print) frec	lene	km	1 3	1702
Sta Registr		31. Date filed (Wonth, Day, Year)	32. Registrar's Signature	south D		,		

			ŕ	For State Registrar			artment o	of Health and of Death	Mental Hygi	_	05890
				1. Decedent's Name (First, Middle, La	ist)				2. Date of Death Month	Day Year	3. Time of Death
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The same of the sa		Funeral			Sex 7. Ag 1√2 M 2□ F	je (In yrs. last birthday 93 Yrs.		Days Hours Min			rthplace (State or Foreign country) Va.
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2/33/06	bash with the MacJap	S. I and Z. Should be abled within 72 hours arien death with the way and if Health and Menhall Hygiene. If Health and Menhall Hygiene. Other traumatic event, It a Medical Examinar must be notified at	tor	Md. 10b. County	A	10c. City, Town or L Balt	ocation timore				10d. Inside City Limits Yes 2 □ No
5	ž Š	or 284	irec	10e. Street and Number			10f. Zip Co		10	g. Citizen of What C	Country?
K	÷	23a	Funeral Director	2815 Kirk Avenu	ie			1218		USA	
. 0	7	teme	nue	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Deceden If Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
0	5-0036	el', or l' Erand	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates:	No	1□Yes 2√	No Specify:		Specify:	Black
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Jame	SA Z	Hygiene. Sther ther ent, I'm M		17. Father's Name (First, Middle, Las	*)	Ь			me (First, Middle, M		
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_	<u>F</u>	and Mental and Mental is marked of aumatic eve	F	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (S	Street and Number or R	ural Route Number,	City or Town, State,	Zip Code)
立	2 3	and c salth a n 27 is		James R. Scott	Son	28	15 Kirk	Avenue, B	altimore,	Md. 21	218
5	e,	Itam Itam		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Name ematory or othe	of er place)	Date 2	Oc. Location - City of	r Town, State
0	E S	rages nent of t ant: If Ita		1 Burial 2 □ Cremation 3 [_Hemoval from State fy)	Mt. Car			8-06	Dundal, M	d.
11	Baltimore,	permin. Prages I and 2 sn Department of Health and Importent: If Itam 27 is m any injury or other traum 20028.		21. Ignature of Funeral Service Lice	nsee / / / /	7- 1		Address of Facility F.H. East		imore, Md . North A	
•		hysician /Medical Examiner	Examiner	23a Part. Enter the disease, or cor shock, or heart failure. List only inmediate Cause (Final disease or condition esuling in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. CER Due to (or as	If the death. Do not erine. BROVAS a consequence of):			c or respiratory arres	st,	Approximate Interval Between Onset and Death
	99	Wrequires mai me deain cermicate be executed bean signed by the attending physician and should be detached for use as the burial-transit	<u></u>	resulting in death) Last	Due to (or as	a consequence of):					
	. 7	I ine deain cel by the attendir ached for use	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic preg □ Other <i>(spec</i>			23d. Date of d Month	elivery Day Year
	S, F	law requires mat me as baan signed by th 2 should be detache	by P	Part II. Other significant conditions	~	_	underlying cau	se given in Part I.			to the cause of death?
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	000	a co	Completed	Anenia					24a. Was an autopsy	24b. Were	autopsy findings available completion of cause of
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	5	Thysic This or	2	1 ☐ Yes 2 No		ent 2 ER/Outpatie			Home 5 ☐ Resider		pecify)
	Division of Vital Records,	lo the hospital of Attending Prystoten: Intel within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	-	ay Year) Injury	М	: Injury at Work? 1 □ Yes 2 □ No	28d. Describe how		Rural Route Number,
	Divi	urs after or an or an or after or all Dirac		4 Homicide determine	building, e	jury - At home, farm, s tc. (Specify)			City or Town,	State)	
		24 ho Fune stely fi	Medical			of examination and/or i		the time, date and place my opinion, death occ			
	4	o the	Me	296. Signature and title of certifier	and mainted a		29c. l	icense number	29	d. Date signed (Mo.	nth, Day, Year)
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		1		30. Name and address of person who	completed cause of			1054	V	1210	Balt MO
		Sta	ate rar	31. Date filed (Month, Day, Year)		rar's Signature	1000	- CS/ M.	1 100	. 146	21217

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of N	Maryland /		ent of F		and M		jiene leg. No.	6	05891
	Physici	an	1. Decedent's Name (First, Middle, La							2. Date of Dea Month	Dav	Year	3. Time of Death
	/Medic	cal	Melda Sar		al.	41-	2's T			Feb.23	'		4:15p ^M
	Examir	ner	4a. Facility Name (If not institution, giver Rock Spring		")		City, Town, or Forest				4c. Count	${ t ford}$	
56	Funeral		5. Social Security Number 6. S	Sex 7.7	Age (In yrs. last b	irthday) If U	nder 1 Year	If Under 2	24 Hrs.	8. Date of Birth)		place (State or Foreign ntry)
371	Director		204 10-7200	1 □ M 2 🔀 F	81	Yrs. Mor	ths Days	Hours	Min.	April9	,1924	PA	ntry)
	and		Usual Residence of Decedent 10a, State 10b, County		10c. City, Toy	vn or Location							10d. Inside City Limits
	Manyl -f sho	tor	MD Baltin	more	Esse								1 ☐ Yes 2 🔀 No
	r 28s	Irec	10e. Street and Number			10	. Zip Code				log. Citizen of	What Cou	ntry?
	23a c	aiD	513 Welbrook B	Road			21221	1			USA		
21215-0036	d within 72 hours after death with the Maryland Jene. r then "naturel", or Items 23a or 28e-f show the Mavical Examiner must be mullied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deceder Armed Force: 1 Yes 25 If Yes, Give Year or Dates	s?]No	If Yes,	ecedent of H specify Cuba ss 2 XNo	ispanic Orig an, Mexican Specify:	gin? (Spe i, Puerto I	city Yes or No- Rican, etc.)	Bla	ce - Americk, White,	
5-0	72 h	etec	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a	. Decedent's (Give kind o	f work done o	durina most	of working	ng	16b. Kind of B	usiness/Ir	dustry
121	within ene. then "	Completed	Efementary/Secondary (0-12)	Coflege (1-4o	r 5+)	Sales	Tuse retired	1)		-	Hecht	Com	pan ģ
d 2			12th 17. Father's Name (First, Middle, Last,)				18. Mother	r's Name	(First, Middle,	Maiden Sumai	ne)	
lan	should be nd Mental marked of matic even	To Be	HArry W. Sarv	/er						Gless		-,	
Maryland	s 1 and 2 should be file f Health and Mental Hyg item 27 is marked othe other traumatic event,		19a. Informant's Name/Relationship (191	b. Mailing Add	ress (Street			l Route Number		State, Zij	Code)
	1 and 2 Health em 27 i		Richard Mattha	i /son				ndy D		e Fall			
altimore,	Pages 1 and of Hee out: If item try or other		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □	Removal from Stat	cemete	of Disposition ery, crematory 100d	or other place	9)			20c. Location		
Itim	그 원론를 .		4 □ Donation 5 □ Other (Specifical Signature of Funeral Service Licer		z dz itv					7700	Baltin	юю	MD
Ba	permi Depa Impo eny is		1 day	200	10.		e and Addres		Con	nellyF	unera	lHom	eofEssex
	m		23a. Part1. Enter the disease, or dom shock, or heart failure. List hily	plications that caus	ed the death Do	not enter the	JU Mai	ce At g, such as c	Ze cardiac o	Baltin r respiratory arr	ore Mi	D 21	Approximate
	Physician		Immediate Cause (Final disease or condition	one cause on each	nine. (* /								Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or a	s a consequence	of):	achie a	11 0.		F 1			
	Examiner		Sequentially list conditions,	b		cong	esrive	H-eac	rr	failure			
	ed isit	Jine	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence		ial f						
	icate be executed physicien and s the burial-transit	Examine	that initiated events resulting in death) Last	c Due to (or a	s a consequence	•							
8760,	sicier sicier s buris	alE	l	d									
9	tificating phy as the	ledical		0									
P.O. Box	that the death certificate be executed the by the attending physicien and detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Petal death at time of death	= '	ic pregnancy (specify)					te of delive	ery Day Year
	The law requires that the ate has been signed by th page 2 should be detache	by Pi	Part II. Other significant conditions of	ontributing to death	but not resulting	in the underlyi	ng cause give	en in Part I.		23e. Did tol	bacco use cont	ribute to t	he cause of death?
rd	w requires that been signed I should be det		Anasarca							1 🗆 Ye	s 2 No	3 Prot	pably 4 □Unknown
Division of Vital Records,	ne law re has be ge 2 sho	Completed	Anemia							24a. Was a		Were auto	psy findings available mpletion of cause of
<u> </u>		Corr	Dementia							pertorr	med?	death?	2 No
Vita	Attending Physician: Thir death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospitaf:			104			(Check only on			
ō	Phys r this ral dir	. To	1 Yes 2 No 27. Manner of Death	1 🗆 Inpa		utpatient 3	DOA CONTE	91: 4 ☐ Nur.		ne 5 Reside			v) Assisted Living
O	ding th. : Aftel	tion	Natural 5 Pending 2 Accident Investigation	28a. Date of fn (Month, D	ay Year)	Injury	28c. fnjury Work	(? Yes 2 □ N		8d. Describe ho	ow injury occur	red	
Visi	Atter r dea ector by the	ifica	3 Suicide 6 Could not be determined	e 28e. Pface of I	njury - At home, fa	arm, street, fa						er or Rura	al Route Number,
	s effer s effer al Direct	Certification:	4 Homeda	building,	etc. (Specify)					City or Town	n, State)		
	To the Hospitel or Attending Physician: Within 24 hours efter death this certific To the Funeral Director: After this certific completely filled in by the funeral director.	edical	one)	niner: On the best	of examination ar	e, death occur nd/or investiga	tion, in my op	oinion, death	i place, a h occurre	d at the time, d	ate and place,	and due to	the cause(s)
.	To To	Σ	29b. Signature and title of certifier	Ily Nan	1.		29c. License				9d. Date signe		
	0.		20 Non- and add	1	V						2/27		
	8		30. Name and address of person who Aly Naguib, MD	2 Co140	ate Dri	(Type, Print)	iite 20	3	Fore	st Hill	, MD	210	50
	Sta Registr	-0-	31. Date filed (Month, Day, Year)	006 32. pogis	trar's Signature	Spen	٧						
DH	MH 17 Rev 1/20	001				6							

			1 - For State Registrar	State of	Marylaı		artment <i>rtificate</i>			ınd M	lental Hy	giene	AUUb	05892
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, La AG 065 S1 4a. Facility Name (If not institution, given	nmon	5' er)		4b. City. T	own. or	Location o	f Death	2. Date of D Month FED	25	y Year	6 1005 AM
	Funeral Director	.*	Bon Secours 5. Social Security Number 6.3	HOSP	: tay	. last birthday) Yrs.	B (2/4	If Under 2	re	8. Date of Bi (Month, D 09-22-1	irth ay, Year,	9. Bi	irthplace (State or Foreign Jountry)
	the Maryland 28e-f ehow)r	Usual Residence of Decedent 10a. Slate 10b. County			ity, Town or Lo					09 22 1		TEAL	10d. Inside City Limits
	ath with the M 23a or 28e-f	Director	MD NA 10e. Street and Number				Baltim		17			10g. Ci	tizen of What C	1 ØYes 2 No
036	ours after des el', or Iteme Exeminer m	by Funeral	1705 W. Mosher Stre	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? ∑ No		Was Decede if Yes, specif	ent of His fy Cubar	spanic Orio	in? (Spe Puerto	cify Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh	nerican Indian, ite, etc.
21215-0036	be filed within 72 ho ital Hygiene. id other then "natur event, the Madical	Completed by	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation ade completed) College (1-4d	or 5+)	(Give	tent's Usual kind of work DO NOT use	done du retired)	uring most	of worki	ng		Gind of Business	s/Industry
Maryland		To Be C	17. Father's Name (First, Middle, Last Andrew Thomas 19a. Informant's Name/Relationship (10b Mailie	og Address /		Ju]	lia D		, Maider	Sumame)	
	1 and 2 s Health ar tem 27 le		Robert Dorsey/ Son 20a. Method of Disposition 1 A Burial 2 Cremation 3 C		20b. I		W. Mosh	er St	reet I	Balto	, MD 212 ate	17	or Town, State,	
Baltimore,	permit. Pages Department of Important: If it eny injury or o		4 Donation 5 Other (Special Signature of Funeral Service Lices	(y)	(9)	tern Sta	r Cemet	ery Address	O3 of Facility				nsville,	MD o, MD 21217
Alle .	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulling in death)	a. Myo	ed the dear tine.	th. Do not ente	er the mode	of dying		ardiac o				Approximate Interval Between Onset and Death 5 Minutes
2	ate be executed hysician end the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq									
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	death 3	Ectopic preg Other (spec						23d. Date of de Month	livery Day Year
ords, P	w requires that been signed t should be deta	þ	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the ur	derlying cau	ıse giver	in Part I.			obacco u Yes 2	_	o the cause of death?
l Rec	The law ate has b pege 2 si	e Completed	25. Was case referred to finedical								1 Yes	psy ormed? 2 No	death?	utopsy findings available completion of cause of 2 No
to !	ding Phys h. After this funeral di	ToB	examiner? 1 Yes 2 No 27. Manner Death 1 Tatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		ijury Day Year)	ER/Outpatien! 28b. Time of Injury	28c	Other Injury a Work?	. 4 🗌 Nurs	sing Hom 2	8d. Describe l	dence how injur	,	
ā	2 # # E		4 Homicide determined 29a. Certifier 1 Certifying Ph	building,	elc. (Specif	y)	occurred at	the time	, date and	place, as	City or Tox	wn, State		ural Route Number,
)	to the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29b. Signature and title of certifier	niner: On the basis and manner	or examina	tion and/or inv	estigation, in	i my opir License r	nion, death	occurre U8	d at the time,	date and 29d. Dat	place, and due e signed (Mont	e to the cause(s)
34	3) Sta	te	30. Name and address of person who should have a discount of the should be s	W.O.	J 196	00 W	est	BA	ltim	iore			Thimore	

			1 - For State Registrar	State of Maryl		artment of F		d Mental Hy	giene	6 05893
	Physici		1. Decedent's Name (First, Middle, La Ruth Marie		berg			2. Date of De Month	Day	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, gire			4b. City, Town, o	r Location of De		ary 24	2000
	LXIIIII		7421 Marriotts	ville Rd.	#2	Marrio	ottsvil	lle	Car	roll
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In)	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H		rth	Birthplace (State or Foreign Country)
Ь	Director		210-20-3440	^{1□ M} 2 X F 80	Yrs.	Worting Days	Tiours it	May 9	1925	VA
	and *		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Aaryla Sho	٥	Md Carrol			sville				1 ☐ Yes 2 TvNo
	28a-	rect	10e. Street and Number		4111000	10f. Zip Code			10g. Citizen of V	Vhat Country?
	With Sa or	0	7421 Marriott	sville Rd.	#2	21104			USA	That obuility !
	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-f show the Mudical Extralner Lust Le incitted at	Funeral Director	11. Marital Status	12. Was Decedent Ever i				' (Specify Yes or No Jerto Rican, etc.)		e - American Indian,
စ	or ite	J.	1 Never Married 2 Married	Armed Forces?				ierto Rican, etc.)		k, White, etc.
93	ral', c	d by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:		Specify	white
21215-0036	72 h	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of	working	16b. Kind of Bu	isiness/Industry
121	of thin	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	-	DO NOT use retired omemaker			domes	tic
7	iled v Hygie ther t		1 2 17. Father's Name (First, Middle, Last	*)		, memaner		Name (First, Middle		
and	antal h	Be C	William Bryan					a Johnson		10)
2	should Me mark matic	ဥ	19a. Informant's Name/Relationship		19b. Mailii	na Address (Street		Rural Route Numb		State. Zin Code)
Z	off ar		Barbara Barr (ne, Md 21797
re,	s 1 ar f Hee item othe		20a. Method of Disposition		b. Place of Dispo		1	Date		City or Town, State
Ë	Page ento nt: # ry or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			en Mem.		I-06	Finksb	urg, Md
altimore, Maryland	permit. Pages 1 and 2 should be itied within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Extraporational Legical and once.		21. Signature of Funeral Service Lice	nsee	22	2. Name and Addre	ss of Facility F	Haight F	uneral	Home & Chape
m	99 = 9		though youth	Herbert				Sykesvil		
В			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the d	leath. Do not ent	er the mode of dyin	ng, such as card	diac or respiratory a	rrest,	Approximate Interval Between
7	Physician		Immediate Cause (Final disease or condition	· Cal	on ect	al Cas	CRF			Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a con		,				
	Examiner	_	Sequentially list conditions,	b						
Т	ed Isit	Jue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or as a con	sequence of):					
	and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a con	sequence of):					
8760,	law requires that the death certificate be executed as been signed by the ettending physicien and 2 should be detached for use as the burial-transit	alE	l							
687	ficate p physics the	Physician/Medical		d						
Box	that the death certific ed by the ettending p detached for use as	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		_ 2000 00 000			23d. Dat	e of delivery
œ.	death	Icla	in the past 12 months?	1 Live birth 2 ☐ F		∃Ectopic pregnancy ∃ Other (s <i>pecify)</i>	<u> </u>		Mor	nth Day Year
P.O.	at the by th tache	hys	9 Unknown	9□ Unknown						
	w requires that s been signed t should be deta	by F	Part II. Dther significant conditions	6.1	_	nderlying cause giv	en in Part I.	23e. Did	obacco use contr	ribute to the cause of death?
Division of Vital Records,	equir sen si ould	ted		None K	40104			_ 10	Yes 2□No	3 ☐ Probably 4 Munknown
e C	ne lawr has be ge 2 sh	ple						24a. Was	psy p	Vere autopsy findings available prior to completion of cause of
<u>=</u>	Physicien: The this certificate hiral director, page	Completed						perfo 1 ☐ Yes		leath? □ Yes 2□ No
Vita	icien Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:		104		Death (Check only		
ot	Phys this ral dir	. To	1 ☐ Yes 2 No 27. Manner of Death	1 inpatient 2	2 ER/Outpatier 28b. Time o		4 🗀 (4012)(1)	g Home 5 Resi	dence 6 Othe	
O	Attending r death. ector: After by the fune	tion	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	r) Injury	Wor	yai k? Yes 2⊟No	200. Describe	now injury occurr	90
isi	Atten deat ctor: y the	fica	3 Suicide 6 Could not b	DB 200 Bloom of Injury A	At home, farm, str			28f. Location /	Street and Numbe	er or Rural Route Number,
2	effer i Direct d in by	Certification:	4 Homicide	building, etc. (Sp	ecify)	, , , , , , , , , , , , , , , , , , , ,		City or To	wn, State)	
	To the Hospitel or Attending Physicien: The within 24 hours effer death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Cartifying Pl	hysician: To the best of my	knowledge, deat	h occurred at the tir	ne, date and pla	ace, and due to the	cause(s) and ma	nner as stated.
	he Ho in 24 he Fu pletel	edical	one) 2 Medical Exa	minar: On the basis of exam and manner stated.	nination and/or in	vestigation, in my o	pinion, death or	ccurred at the time,	date and place, a	and due to the cause(s)
	To t With To t	Σ	29b. Signature and title of certifier			29c. Licens			- /	1 (Month, Day, Year)
	,		I bowned of	wif , w.	ν.	10%			2/2	7/ 6
	ř.		30. Name and address of person who	completed cause of death (Item 23a) (Type,	Print)	4.	120 -1	49	- /41 / 3 1 /
)		31. Date filed (Month, Day, Year)	nt Z M.D.	ionature	· CR44	er st	. well	M. H JT	- Md. 2113 7
	Sta Registr	_		2006	JA A	BALL				4/06 - Md. 21157
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			For Stata Registrar		State o	f Maryla	nd / Dep <i>Ce</i>	artmer <i>rtifica</i> :			nd Men		ene	06	050	395
H	Physici	an	1. Decedent's Name (First, M	liddle, Last)	,			<i>C</i>	11			Date of Deat	Day.	Year	3. Time o	
	/Medic	cal	(arroll		<u></u>			Smi				bruary	24	2006	2:01	6 Рм
i	Examir	ner	4a. Facility Name (If not insti		Bavview		Center	4b. City		more	Death	,		ty of Death Finere	City	
	Funeral		5. Social Security Number	6. Sex			s. last birthday)		r 1 Year	If Under 24		Date of Birth	-	9. Birthr	place (State	or Foreign
	Director		219-22-9742	1፟፟፟፟፟፟፟፟	M 2□F	80	Yrs.	Months	Days	Hours	Min. (Month, Day,	Year) 1925	Nort	h Car	olina
	pue *		Usual Residence of Deceder 10a. State 10b. Co			10c. C	City, Town or Lo	ocation						1	Od. Inside C	Titu Limito
	Maryl f eho	5	Maryland	•	timore		,			Edgeme	ere			Ι.		s 2 ŽNo
	1 the	rec	10e. Street and Number					10f. Zi	p Code			10	g. Citizen o	f What Cour	ntry?	
	be filed within 72 hours after death with the Maryland thygiene. Hygiene. d chear than "neturel", or itama 23a or 28a-f ehow event, Ita Modical Extrainer mant be motified at	Funeral Director	2823 Ross 2	Ave.						21219	9		Unite	d Stat	es	
	tama tama	ner	11. Marital Status		12. Was Dec	edent Ever in orces?	U.S. 13.	Was Dece	dent of Hi	spanic Origin n, Mexican, P	1? (Specify Puerto Rica	Yes or No- n, etc.)		ace - Americ		
36	s afte	by Fu	1 Never Married 2∑ 3 Widowed 4 Divo		1 ⊠Yes If Yes, Giv Year or D	2 □ No Ve WW		1 ☐ Yes					Spec	ifv-		
8	2 hour	edit	15. Dec	edent's Educ	cation	ales:	16a. Dece	dent's Usu	ial Occupa	ition			6h Kind of	Business/Inc	White	
Maryland 21215-0036	Maria 7	Completed	(Specify only h Elementary/Secondary (0-	ghest grade	College (1-4or 5+)	(Give	kind of wo DO NOT i	ork done d ise retired,	uring most of	f working				200.17	
21	filed wil Hygien other the	Sol	12 Years					Dies	el Me	chanic				nanica	.1	
מש	t be fil ntal H od ott	Be	17. Father's Name (First, Mic							18. Mother's				ame)		
چ	M M M	၉	Thomas V. S		na Print)		10h Maili	a a Addros	o (Stroot o	nd Number o		Campbe		- C-1- 7'-	0.71	
<u>@</u>	4734		Patricia Ba		(Daugh	ter)		23 Hu				mere,			21219	
ē,	트로 들 등		20a. Method of Disposition				Place of Dispo	osition (Na	me of		Date	2	0c. Location	n - City or To	wn, State	
Ē	it. Pages ertment of ortant: if it injury or o		1X Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Other	ion 3 ⊟R er <i>(Specify)</i>	emoval from	State G	ardens				2/28/	2006	Balt	imore,	Mary	land
saltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Ser	vice Lipense	9 /	1 1	7) 2	Name a	nd Addres Ruck	funera	al Hor	me of	Dunda:	lk, In	ıc.	
	70 E E 9		1)4		. (all		7922	Wise	Ave.	Dunda	alk, M	aryla	nd 21	.222	
			23a. Part1 Enter the disease snock, or heart failure.	e, or compli List only on	e cause on e	aused the dea ach line.	Do not eni	er the mod	de of dying	, such as car	rdiac or res	piratory arre	st,		Approxima Interval Be Onset and	tween
	nysician /Medical	Ϊij	Immediate Cause (Final disease or condition resulting in death)	a a		201	MI									
	Examiner				Due to	or as a conse	quence of):	- 6	land						Hours +	o da
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ь	Dua to	CMT C	querice of).	1 0	HEEL					_		7
	nd nd transi	Examine	mat initiated events	1 0	A	rute M	veloid L	euke	Mia						Month	15
Ć,	icate be executed physicien and the burial-transit	EX	resulting in death) Last		_	or as a conse	A 1	0 -							Years	0
09/89	certificate be executed adding physicien and use as the burial-transit	dlcal		d		cenary'	Artir		05						TORIS	>
X O	eath certific attending p	iclan/Me	IF FEMALE: 23b. Was decedent pregnan	. 2:		come of pregr							23d D	ate of delive	100	
מ	death e atter	Iclar	in the past 12 months?		4☐Pregn	inth 2 ☐ Fet ant at time of		DEctopic p Other (sa						onth	-	Year
Ο,	ch the	hysi	9 Unknown		9□ Unkno									-		
s,	requires thet the de- een signed by the a hould be detached for	by P	Part II. Other significant cor	ditions con	tributing to de	eath but not re	sulting in the u	nderlying o	ause give	n in Part I.		23e. Did toba		ntribute to th	e cause of	death?
	9 9 9	eted				-					- Project	1 🗹 Yes	2 □ No	3 Prob	ably 4 🗍	Unknown
Ō.	e iaw hasb	ompleted									- '	24a. Was an autopsy		. Were autor prior to con death?	psy findings apletion of c	available cause of
	ding Fnysicians. The lav h. After this certificate has funeral director, page 2.	e Co	25. Was case referred to me	tion				_					ØNo		2□ No	
5	r this certific	To Be	examiner?		ospital: 15/1	npatient 2] ER/Outpatier	1 3 D D	Othe	26. Place of		eck onlv one 5 □ Resider		thas (Casait	41	-
_ 1	ter thi		27. Manner of Death			of Injury th, Day Year)	28b. Time of		28c. Injury Work			Describe hov			/	
	Attending r death. ector: After by the fune	atlo		estigation	(1010111	n, buy rour,	Піцагу	М		es 2□No						
DIVISION	fier de linect	Certification;		uld not be termined	28e. Place buildii	of Injury - At h	nome, farm, str	eet, factor	y, office		28f. L	ocation (Stre	et and Num State)	ber or Rura	Route Nun	nber,
ָ נ	ours e		29a. Certifier 1 Cert	fuina Phys	iciens To the	hast of my la	- de de de de de									
	24 hc 24 hc e Fun letely	edical	(Check only 2 Mad	cal Examin	er: On the ba	asis of examin ner stated.	owledge, death ation and/or in	vestigation	, in my opi	inion, death o	occurred at	the time, dat	e and place	anner as st , and due to	ated. the cause(:	s)
	io the nospital of Attending within 24 hours effer death. To the Funerel Director: Aft completely filled in by the fun	Me	29b. Signature and title of ce	tifier	111			290	c. License	number		29	d. Date sign	ed (Month, l	Day, Year)	
			> Yeffrey	High	fill,	MD			RE	5-01	00	F	ebruai	ry 24	, 20	06
6	1/		30. Name and address of per	1	4	e of death (Ite			MD	0	31224			1		
	Sta	to.	4940 E o 31. Date filed (Month, Day, Y	ear)	Ave.	gistrar's Sign	Baltin	iore,	I'IU	d	11007					
	Registra		FEB		006	GERRS.	S. A.	carde	,							

			State of Maryland / Depar 1- State Registra Amend Item #5 Per FH G853 3/0990		lental Hygie Reg.	4000 00000
	Physici	3	1. Decedent's Name (First, Middle, Last) Altus Isabelle Senft		Day Year 12:29 PM	
	/Medio Examin		4a. Facility Named (If not institution, give street and number) 4b. City, Town, or Location of Death Baltiware n/a			
	Funeral Director		210	If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 22	8. Date of Birth (Month, Day, Ye Sept 3, 2	9. Birthplace (State or Foreign Country) 2005 Maryland
nd 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It was 23 or 28e-f show Itam 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at	To Be Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Deceder (Give kirk) (If A. Deceder (If B. Deceder		ecify Yes or No- Rican, etc.)	10d. Inside City Limits 1 □ Yes 2 ▼No Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White b. Kind of Business/Industry
			Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a 17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	
Maryland				Jennifer May Abel ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Beckleysville Road, Manchester, MD 21102		
Baltimore, I	permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once.		20a. Method of Disposition 1 🛣 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, cremation 2ub. Place of Disposition 2ub.	ion (Name of tory or other place) 3/1/11ey Mem. Gardens	oate 20c '06 Ti	Location - City or Town, State
Bal	Depar Impor any ir	22. Name and Address of Facility, Lemmon Funeral Home of Dulaney Valley 10 W. Padonia Road, Timonium, MD 2109. 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.				
60, V	es the	Completed by Physician/Medical Examiner	shoe', or heart failure. List only one cause of each line. Immediae Cause (rinal disease it conditions if any, Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Interval Between Onset and Death Pespication Failure Due to (or as a consequence of):			
Division of Vital Records, P.O. Box 68760,			1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 C	ctopic pregnancy tther (specify)	22a Did tahaa	23d. Date of delivery Month Day Year
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - "Pumpney" Hyper Huston -		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?	
		o Be Co	25. Was case referred to medical examiner? Hospital: Other			
		Medical Certification; To	27. Manner of Death 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 2 Accident 3 Suicide 4 Homicide 4 Homicide 28b. Place of Injury 4 Nork? 1 Yes 2 No 28b. Time of Injury 4 Work? 1 Yes 2 No 28b. Location (Street and Number or Rural Route Number, building, etc. (Specify)			
Ō			29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
)	To the within 2 To the comple		29b Signature and the programmer 7. Neva Mi	29c. License number \$\int 67150\$	29d.	Date signed (Month. Day, Year) 2/25/2006
	30, Name and address of person who completed cause of death (Item 28a) (Type, Pript) & Fernando Mena 22 South Friend & Fernando Mena 22 South Friend & Fernando Mena 21201					
State Registrar FEB 2 8 2006 DHMH 17 Rev 1/2001						

ORIGINAL

Physician Alvina Nathan Smith Alvina Nathan Smith Sm				For State Registrar	State o	f Marylai			nt of H te of L		and Mo	ental Hy	gien Reg. N	HIII	05	897
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Second Second Planton Part		Examin	ier			,		4b. City	, Town, or	Location of	f Death		40	. County of Deat	h	
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Physician Modical Examiner 23a Part i. Error the disease, or complications that caused the death. Do not enter the mode of dying, such as cardador or respiratory arrest. Approximate shock or heart faulure. List only one cause on each line. The death. Do not enter the mode of dying, such as cardador or respiratory arrest. Approximate shock or heart faulure. List only one cause on each line. The death. Do not enter the mode of dying, such as cardador or respiratory arrest. Approximate shock or heart faulure. List only one cause on each line. The death. Do not enter the mode of dying, such as cardador or respiratory arrest. Approximate shock or heart faulure. List only one cause on each line. The death. Do not enter the mode of dying, such as cardador or respiratory arrest. Approximate shock or heart faulure. List only one cause on each line. The death. Do not enter the mode of dying, such as cardador or respiratory arrest. Approximate shock or heart faulure. List only one cause on each line. The death of the cause of death. The death of the death of the death. The death of the	alti	partm porta y inju					22	2. Name a	nd Addres	s of Facility	Robe	ert A.	Pum	phrey Fu	nera	1 Home/
Physician Medical Examiner Physician Examiner Physician Medical Examiner Physician	<u> </u>	8978		3 Birds	Perry	· MO	0803 R	ockvi ockvi	lle,	Inc. Mary	300 land) West 2085(Mon 1-28	tgomery 05	Aven	ue
Paysician Machina Ma				23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the dea	th. Do not ent	er the mo	de of dying	, such as o	cardiac or	respiratory a	rrest,		Approx	imate I Between
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The statistics events of the statistics of the s	13.	MA	er	Sequentially list conditions, if any, leading to immediate	b. Due to	or as a consec	quence of):	Near	TK	Ji W	<u></u>				45	3
Spood Spoo	2	outed ansit	amin	cause. Enter Underlying Cause (Disease or injury that initiated events	S CEY	awar	u av	KIN	ں) ماد	1180	020				1	ve .
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The state of the control of the cont	Sion	andin sath. or: Afr	atlo	2 Accident investig	gation	n, Day 1 ear)	Injury				io					
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and due to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suhair Abulfarag, M.D. 15215 Shady Grove Road, #100, Rockville, Maryland 20850	<u> </u>	or Att	Ħ	determ	ined 288. Place	of Injury - At h	ome, farm, str	eet, factor	y, office		28	Bf. Location (: City or Tox	Street ar	nd Number or Ru e)	ral Route	Number,
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Suhair Abulfarag, M.D. 15215 Shady Grove Road, #100, Rockville, Maryland 20850				S. Alsel	4 avois	· MI)		D3	139	1		Fe	brucity	24	2006
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			for State Registrar	State of Maryl	and / Depa		Health and I	Mental Hyg	2006	. 05898
	ę/s		Decedent's Name (First, Middle, Last)		Timouto or	Douin	2. Date of Dea	ieg. 140.	3. Time of Death
-	Physic /Medi Examir	cal	Mary A. Simon. 4a. Fecility Name (If not institution, give	aire		4h City Town	or Location of Death	Month Februar	Day Year Y 17, 2006	3:00 AM M
Н	E X a i i i i	ler					_	,		
	Funeral	22	441 Shady Lan 5. Social Security Number 6. Se		rs. last birthday)	Pasa	If Under 24 Hrs.	8. Date of Birth	Anne Aru	INGE L Birthplace (State or Foreign Country)
	Director		212-12-2164 Usual Residence of Decedent	™ 27 F 86	Yrs.	Months Days	Hours Min.	Dec 20,		country) aryland
	Marylan -f show	tor	10a. State 10b. County MD Anne Arun		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 288	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	
	th wit	a D	441 Shady Lane			21	122		USA	
	dea arme	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.		Hispanic Origin? (S) pan, Mexican, Puerto	pecify Yes or No-	14. Race - Ar	nerican Indian,
036	ours after rel', or lt	by Fu	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 ☐ Yes 2🎇 No		nican, etc.)	Specify: wh	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Iteme 23a or 23a-1 show ship injury or other traumatic event. The Medical Exacting must be rightled at once.	Completed by Funeral	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of work	king	16b. Kind of Busines	ss/Industry
7	giene grene er the	E O	12	2	mercha	ndise bu	ver		Hutzlova	Dept store
ם	be filed stal Hygie od other	Be (17. Father's Name (First, Middle, Last)				<i>y</i>	e (First, Middle, I	Maiden Surname)	bept store
<u>X</u>	2 should be and Mental is marked sumatic ev	ု	Aldo MacDonald				Jennie M	artin		
Maryland	2 short and is m		19a. Informant's Name/Relationship (Ty						, City or Town, State	, Zip Code)
	1 and 2 Health Iem 27		Penny Simonaire/d				ne Pasade		21122	
Baltimore,	it. Pages I inment of t- intant: If ite njury or ot	3	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☒ Donation 5 ☐ Other (Specify)		 Place of Dispose cemetery, cren 	sition (Name of natory or other pla	ce)	Date	20c. Location - City o	or Town, State
Balt	permit. Departrimports sny inju		21. Signature of Fuperal Service License Ronald S. V	Nage forest	or St	Name and Addre	omy Board	1 655 W.	Baltimore	Street
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-	ate be executed nysicien and he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons						
-	70	Icai								
.O. BOX	nt the death certifica by the ettending ph tached for use as tt	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Ho 9 □ Unknown	3c. If yes, outcome of prec 1 ☐ Live birth 2 ☐ Fi 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3 🗌	Ectopic pregnancy Other (specify)	y		23d. Date of de Month	elivery Day Year
Hecords, P.	The law requires that the te has been signed by the page 2 should be detached.	þ	Part II. Other significant conditions con	tributing to death but not r	esulting in the un	derlying cause giv	ren in Part I.			to the cause of death?
Ö	w req	leted								
		Compl						24a. Was an autopsy perform	prior to death?	autopsy findings available completion of cause of
VICA	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			26. Place of Deat			
5	Phys this aldi	T.	1 Yes 2 No	1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatient 28b. Time of		4 Li Nursing Ho		nce 6 Other (Spe	ecify)
SION	of or Attending P after death. I Director: After t d in by the funera	catlon	1-⊟Natural 5 □ Pending investigation	(Month, Day Year)	Injury	28c. Injur Wor M 1 🗆	y at k? Yes 2 □ No	28d. Describe ho	w injury occurred	
	itel or At rs after d al Direct led in by	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre cify)	et, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier Check only one)	ician: To the best of my k er: On the basis of exami and manner stated.	nowledge, death nation and/or inve	occurred at the tir estigation, in my o	ne, date and place, pinion, death occurr	and due to the car ed at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To t Withi To til	Σ	29b. Signature and title of Certifier			29c. Licens			d. Date signed (Mon	
			30. Name and address of person who cor	moleted cause of death (It	am 23a) (Tugo P	D4	14243	F	ebruars	228
			Fucade IV N	N DZI O	· Rolliv	15 Koro	e Costen	sville	mo zi	228
	Stat Registra	4.4	31. Date filed (Month, Day, Year)	32 Registrar's Sig	inature .	all so				

			1 - For State Registrar	State of Ma		artment of Health a ertificate of Death	nd Mental Hygie	ZUUh	05899
Ħ	Physici	an	Decedent's Name (First, Middle, Las	t)		3. 146	2. Date of Death Month	Day Year	3. Time of Death
4	/Medio	cal	4n Thon V 4a. Facility Name (If not institution, give	street and number)) m 1 Th 4b. City, Town, or Location of	February	23 2006 4c. County of Death	10:49 AM
1	Examir	ner	The Johns Hook	ins Hose	pital	Baltimore	City		/A
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthda)		4 Hrs. 8/Date of Birth Min. 8/Date of Birth (Month, Day, Ye Jan 8, 19	9. Birth	place (State or Foreign
	Director		214-50-9580	X M 2□ F	57 Yrs.	Worters Days Hours	Jan 8, 19	949	vlaryland
	land wo		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or t	ocation			10d. Inside City Limits
	Many	ţo	Maryland N	I/A		Baltimore			1 X Yes 2 □ No
	or 28	Oirec	10e. Street and Number			10f. Zip Code	1	Citizen of What Cou	
	ath w	rail	2580 Edmondson Aven			2122		U.S.	
Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any njury or other traumatic svent, the Musical Examinar must be notified at ances.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Endemed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates:	verin U.S. 13	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 Yes 2 XNo Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ameri Black, White Specify:	
2 Q	72 ho	eted	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dec	edent's Usual Occupation be kind of work done during most	of working	. Kind of Business/Ir	ndustry
2	Men.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use retired)	or working	Boat	yard
7	Hygie ther t		17. Father's Name (First, Middle, Last)				's Name (First, Middle, Maid	den Surname)	
aŭ	id be ked o ked o ic sve	To Be		Carter Lynn				n Lynn	
ary	shou and M smar umat	٦	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mai	ing Address (Street and Number	or Rural Route Number, Ci	ty or Town, State, Zi	c Code)
Σ,	and 2 ealth m 27 i		Lillian Lynn Mother			2580 Edmondson Aver			
Baltimore,	Peges 1 ment of Hi ant: If its		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	n	1	osition (Name of imatory or other place) ro Crematory, Inc.	02/24/06	Catonsville,	
Ball	Depart Depart Import any in		21. Signature of Funeral ferrice Licen	Ju 23te	TOR	2. Name and Address of Facility Estep Brothers I 1300 Eutaw Pla	Funeral Service, P. ce Baltimore, Md 2	A. 1217	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused to one cause on each line	ne death. Do not er	nter the mode of dying, such as c	ardiac or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Multi-s	system	organ failur	R	2	weeks
	/Medical Examiner		f and the second	0	consequence of):	J			wizek
	Ŷ.	er	Sequentially list conditions, if any, leading to immediate	b. De DSIS Due to (or as a	consequence of):				The state of the s
V	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	o. HIV				8	Byears.
, 0,	oe exe cien a vurial-1	I Ex	resulting in death) Last	Due to (or as a	consequence of):				
8760,	physic the b	dical		d					
Вох 6	The law requires thet the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by Physician/Me	in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetel death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deliv	ery Day Year
o.	thet the de led by the a detached f	hysi	1 Yes 2 No 9 Unknown	9□ Unknown	no or abatir o				
ď.	res thet igned b be deta	y P	Part II. Other significant conditions co	entributing to death but	not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
ord:	w require been sig should b		,				1 ☐ Yes	2 □ No 3 □ Pro	pably 4 Unknown
		Completed					24a. Was an autopsy performed 1 \(\superset \text{Yes}\)	prior to co	opsy findings available impletion of cause of
Vita	ysician: The Is certificate he director, page	Be	25. Was case referred to medical examiner?	Hospital:		100	of Death (Check only one)		
o	Phys this ral dir	<u>۲.</u>	1 Yes 2 No 27. Manner of Death	Inpatient			sing Home 5 Residence		(y)
0	l or Attending Ph after death. Director: After th I in by the funeral	Certification:	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	rear) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ N		njury occurred	
N S	Atter or dea ector by the	Hica	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of Injur	/ - At home, farm, si		28f. Location (Street		al Route Number,
ā	tal or Ars after st Dire	Cert	4 - Normolde	building, etc.	(эреспу)		City or Town, St	rate)	
	To the Hospital or Attending Physician: within 24 hours after death or 20 ths Funerst Director. After this certified completely filled in by the funeral director, it	edical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best of iner: On the basis of e and manner state	xamination and/or ii	th occurred at the time, date and ovestigation, in my opinion, death	place, and due to the cause a occurred at the time, date	e(s) and manner as s and place, and due t	tated. o the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	io M		29c. License number		Date signed (Month,	3, 2006
	4		30. Name and address of person who co	1 1 1 1 1	th (Item 23a) (Type	, Print)			77 (1)
	Sto	to	31. Date filed (Month, Day, Year)	32. Registrar	J NOYTH s Signature	Wolfe Street,	Baltimore 1	10 2128	31-4100.
	Sta Registr		FFB 2 8 20		•	bank			
DHN	AH 17 Rev 1/20	001	110001	100 1 100	The state of the s				

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

200.000	1 - For State Registrar		artment of Health and I rtificate of Death	Mental Hygie	211116	05901
Physician	1. Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death
/Medical	Joseph	Vernon	Sembly		25 2006	9:25 A M
Examiner	4a. Facility Name (If not institution, give street at	nd number)	4b. City, Town, or Location of Death Baltimose	1	4c. County of Death	1
* * *	Sinai Hospital of Bo	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Q Birth	polace (State or Foreign
Funeral Director	216-18-4945 1X M 20		Months Days Hours Min.	(Month, Day, Ye	22 Con	nplace (State or Foreign untry) MD
	Usual Residence of Decedent			0, 22		
arylar	10a. State 10b. County MD NA	10c. City, Town or Lo				10d. Inside City Limits 1 XYes 2 No
6 ufter death with the Maryland ur teme 23a or 28a-f show older must be notified at Funeral Director		Bartimo				
a or 2	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	untry?
ne 23	4942 Edgemere Ave	Decedent Ever in U.S. 13.	21215 Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	U . S . A 14. Race - Amer	
6 6 after or ftee	1 XNever Married 2 Married 1	Yes 2 X No		o Rican, etc.)	Black, White	
Vernon 15-0036 72 hours after death with the Marylar "naturel", or items 23s or 28s-1 show after Exercises invest to notified at leted by Funeral Director	3 ☐ Widowed 4 ☐ Divorced Yea	r or Dates:	1 ☐ Yes 2【 No Specify:		Specify:	Black
21215-00 ed within 72 hou yegiene. See then 'nature it, it a Marical E. Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 16b	o. Kind of Business/I	ndustry
within then		ege (1-4or 5+)	Laborer	ν	arious .	Jobs
Jose phy yland 21 yland 21 white Hygier Mental Hygier arked other than arked other than To Be Cor	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid		
/lan	Vernon Sembly		Edith	Ennis		
Semby, Joseph Vernon Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene, Important: If term 27 is marked other then "naturel", or iteme 23a or 28a-1 show only injury or other traumatic event, the Medical Examinar the motified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Prin	t) 19b. Maili	ng Address (Street and Number or Ru	ral Route Number, Ci	ity or Town, State, Z	ip Code)
and salth maz7	Yolanda Bryant-Gre					21215
Semby altimore, mit. Pages 1 at partition to Hase portrant: If them y injury or othe	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	ITOITI State	sition (Name of matory or other place)		c. Location - City or 1	
Se Itim			rematory Inc.	2/27/06	Baltimo	ce, Md
Bal permi Popa Impopa eny in	21. Signature of Funeral Service Licensee		Pampand Addiess of Facility			03075
5.	23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one caus		OO Wabash Ave, or the mode of dying, such as cardiac			21215 Approximate
Physician	Immediate Cause (Final			•		Interval Between Onset and Death
/Medical	resulting in death)	mastric Adenaca ue to (or as a consequence of):	rcinoma			7 days
Examiner	Sequentially list conditions					
Je J	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequence of):				
60, % be executed icien and burial-transit	triat initiated events	ue to (or as a consequence of):				
		de to (or as a consequence or).				
687 ficate physis the lasthe	d					
Records, P.O. Box 68760, The law requires that the death certificate be exite has been signed by the attending physicien bage 2 should be detached for use as the burian completed by Physician/Medical Excompleted by Physician/Medical Ex		s, outcome of pregnancy	-		23d. Date of deliv	very
death death re atte	in the past 12 months?		Ectopic pregnancy Other (specify)		Month	Day Year
P.O. that the dot by the detached	9 Unknown					
	Part II. Other significant conditions contribution		ous Throm books		co use contribute to	• 1
orc requi	Bilateral Lower Ex	remny beep von	003 191819 2015			bably 4 DUnknown
II Record The law requir				24a. Was an autopsy performed	prior to c	opsy findings available ompletion of cause of
Vital Receiption: The law certificate has rector, page 2	25. Was case referred to medical			1 ☐ Yes 2 🔀		2 No
of Vital Physician: This certificital director,	examiner? 1 Yes 2 No Hospital:	1 Inpatienf 2 ER/Outpatier	0.4	th (Check only one) ome 5 Residence	a 6 DOther (Case	.4.)
g Physer this ser this seral dimeral d	27. Manner of Death 28a.	Date of Injury (Month, Day Year) 28b. Time o		28d. Describe how in		1197
ondin sath. or: Aft	2 Accident investigation	(Month, Day 1 day)	M 1 Yes 2 No			
Division of Vital Records, tal or Attending Physician: The law requires this after death. at Director: After this certificate has been signed in by the funeral director, page 2 should be coertification: To Be Completed by	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	t and Number or Rui	al Route Number,
	20- Cartillar	To the book of				
he Hosp in 24 hou he Fune pletely fil	(Check only 2 Medical Examiner: On	To the best of my knowledge, deat the basis of examination and/or in I manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
o the orthographic	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month	, Day, Year)
F S F O	Down Fitting	4.0	RES 000	Fe!	bruary 2:	5, 2006
λ	30 Name and address of person who complete	cause of death (Item 23a) (Type	Print)			
, ,	TORIN FITTON, MD, S 31. Date filed (Month Par Year) 8 2006	ing Hospital of	altemore, 2401 W 1	Belvedere Ave	e, Baltimor	e, MD 21215
State Registrar	31. Date filed (Month, Day, Year) 8 2006	32 Registrar's Signature	was the same of th			

			Please 1	ype or Pri	nt in Black In	delible lnk	. Ensure All	Copies A	Are Legible.	
			1 - For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of I <i>rtificate of</i>			ene 9. No. 0 0 6	05902
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic		BELLE		SI	LBERSTEI		FEBRUAR'		1:50 P M
	Examin	ier	4a. Facility Name (If not institution, give HEBREW HOME OF GR 5. Social Security Number 6. Sec	EATER WAS	HINGTON e (In yrs. last birthday)	R0	CKVILLE If Under 24 Hrs.	9 Date of Birth		GOMERY
	Funeral Director			M 2015	82 Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day, AUG. 10,	Year) 2.5 000	place (State or Foreign intry) PA
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-fel	ctor	MD MONT	GOMERY	ROCK	VILLE				1 ☐ Yes 2 No
	with the	Funeral Director	10e. Street and Number 6131 MONTROSE ROA	D #NEGO		10f. Zip Code	20850	10	g. Citizen of What Cou	•
	Jeath In 23	eral		12. Was Decedent	Ever in U.S. 13.	Was Decedent of I		cify Yes or No-	14. Race - Amer	USA ican Indian,
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 te marked other then "neturel", or items 23a or 28a-f ehow other treumatic event, the Medical Exam actinual terricities and other treumatic event, the Medical Exam actinual terricities at	by	1 ☐ Never Married 2 ☐ Married 3 🂢 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:	No	If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto F Specity:	Rican, etc.)	Black, White	
15-0	"netu	Completed	15. Decedent's Edu (Specify only highest grad	cation completed)	16a. Dece (Give	dent's Usual Occup	pation during most of working d)	ng 1	6b. Kind of Business/I	ndustry
212	filed withii Hygiene. ther then int, the M	omp	Elementary/Secondary (0-12)	College (1-4or	D+)	SPERSON	ia)		MAGAZINE	
bu	be filed Ital Hyg od othe event,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	laiden Sumame)	
yla	2 should be and Mental le marked o eumatic eve	To	JOSEPH		PERL		ROSE			ROTH
Maryland	d 2 sh th and 7 le m treum		19a. Informant's Name/Relationship (Ty ELLEN MAIDMAN-TAN	*		-			City or Town, State, Zi	
	s 1 and 2 f Health item 27 other tr		20a. Method of Disposition		20b. Place of Dispo		! D		Oc. Location - City or T	
altimore,			1 ☐ Burial 2 ☐ Cremation 3 🎘 F 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	MT. SHAR		' I	/2006	SPRINGFIEL	D, PA
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens	0.41	2	2. Name and Addre	ess of Facility SOL	LEVINSO	ON & BROS.	, INC.
	40= 60		23a. Part1. Enter the disease, or compli	cations that caused					IKESVILLE,	
	Pnysician		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each li	ne.		ON'S	_		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a consequence of):	1/1/1/	ONS.	1120	7136	
	Examiner	L	Sequentially list conditions, if any, leading to immediate							
V	rted nsit	Examiner	Cause (Disease or injury	Due to (or as	a consequence of):					
Ć.	be executed ician and burial-transit	Exal	that initiated events resulting in death) Last		a consequence of):					
68760	certificate be executed iding physician and use as the burial-transit	Icai								
	ertifica ding pl	/Med	IF FEMALE:	20 If yes outcome	of programmy					
O. Box	death e atter d for u	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of deliv Month	very Day Year
ds, P	res tha igned be de	by	Part II. Other significant conditions cor	tributing to death b	ut not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	
Records,	s been s s should	Completed						24a. Was an		opsy findings available
l Re	The lav ate has page 2:	Com						autopsy perform		ompletion of cause of 2 No
Vital	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	la anitali			26. Place of Death			
of	Phys this ral di	. To	1 ☐ Yes 2X No 27. Manner of Death	ospital: 1 ☐ Inpatie 28a. Date of Inju		IT 3L DOA		ne 5 🗌 Residen 8d. Describe how	nce 6 Other (Speci	<i>fy</i>)
Division	Attending I r death. ector: After by the funer	cation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Da	y Year) Injury	Wo	rk?]Yes 2□No	04. 5000150 1104	winquity obconica	
Divi	F = E = C	Certification:	4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, str c. (Specify)	eet, factory, office	2	8f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	To the Hospitel of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	sician: To the best ner: On the basis o and manner st	of my knowledge, deat f examination and/or in ated.	h occurred at the til vestigation, in my o	me, date and place, a opinion, death occurre	nd due to the cau d at the time, dat	use(s) and manner as a te and place, and due t	stated. to the cause(s)
	To the within 2 To the complet	×	29b. Signature and title of certifier			29c. Licens	se number	-1/ 290	d. Date signed (Month,	Day, Year)
	/		Druen	\bigcirc	enon	(V) 10	01508	1 1	513 RUARY	24,2006
	3		30 Name and address of person who co	ac, run	eath (Item 23a) (Type,	iontro	e Rely /2	20 dCm	le mo	20852
£.	Sta Registr		FEB 2 8 200	W.	ar a digitalitie	also de	,		/	

			1 - For State Registrar	State of M	laryland				ealth a Death	nd M		giene	00	5	05904
	Physici		1. Decedent's Name (First, Middle, Las George F. Tins								2. Date of De Month Februar	ath	2 200	Year 6	3. Time of Death 10:06p M
	/Medic Examir		4a. Facility Name (If not institution, give Washington Adven					Town, or	Location of Park	Death		4c.	County o	f Death	1
**************************************	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	9X 7. A ▲ M 2 F	ge (In yrs. las	st birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da Jul. 5	th ly, Year) 191	.5	9. Birthp Coun Geo1	lace (State or Foreign try) gia
	Maryland	tor	10a. State 10b. County Maryland Anne Art	ınde1	10c. City, Odent	Town or Lo	cation							1	0d. Inside City Limits 1 X Yes 2 No
	th with the 23a or 28	al Director	10e. Street and Number 303 Assembly Poin	t Court			10f. Zip	Code	2111	L3		10g. Citi	zen of WI	hat Cour	USA
9000	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or items 23a or 28s-f ehow event, I've Medical Exerting mast be notilized at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 XYes 2 ☐ If Yes, Give Year or Dates:	? ^{No} 1942-	1	Was Dece f Yes, spe l ☐ Yes	crfy Cubar	spanic Origi n, Mexican, Specify:	in? (Spe Puerto	ecify Yes or No Rican, etc.)	-		, White,	an Indian, etc. Black
Maryland 21215-0036	d within 72 t giene. or then "net	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or		life. L	kind of wo DO NOT u	al Occupa ork done di se retired) Worke	uring most o	of worki	ing		Pos		dustry Service
yland	2 should be filed and Mental Hygid Is marked other aumatic event,	To Be (17. Father's Name (First, Middle, Last) Robert Tinsley						Anni	Le D	e (First, Middle, uncan				
e, Mar	ges 1 and 2 should nt of Health and Mer if item 27 le marke or other traumatic		19a. Informant's Name/Relationship (7 Nichelle Schoultz 20a. Method of Disposition		ghter	19b. Mailin	Assem	bley	Point	Ct		ton,	MD	211	13
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 It any injury or other tra		1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	cem	netery, crem C nut (natory or o Grove	Cem	. 2/	/26/	2006	Herr	ndon,	Vir	wn, State
Bal	Depa Impo any k		21. Signature of Funeral Service Licen:	W, M	ull	F22	Name ar	inco inco Iadei	of Facility Ln. Fur asburg	nera Ro	1 Home ad, Bre	entwo	od,	MD	20722
8760,7	Physician physician and physician and physician and physician and the print the print the print the print the print the print the physician and physician an	dicai Examiner	23a. Part 1. Enter the disease, or comp. shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Athorna Due to (or as b. Due to (or as c.	a consequer	heref					tery c		E.		Approximate Interval Between Onset and Death
.O. Box 6	The law requires that the death certificat site has been signed by the attending phy bage 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3	Ectopic pr Other (sp					2	3d. Date Month		ry Day Year
ords, P	w requires that been signed b should be det	ed by PI	Part II. Other significant conditions co	ntributing to death b	ut not resultir	ng in the un	nderlying c	ause giver	n in Part I.						e cause of death?
Vital Records,		Completed									24a. Was autop perfor 1 🗆 Yes	sy	prio dea	or to con ath?	isy findings available inpletion of cause of
	nysicla ns certi directo	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpati	ent 2 ER	VOutpatient	3 DC	Other			(Check only on the 5 ☐ Resid		Other	(Specify	
Division of	Attending Physiclan: It death. ector: After this certific. by the funeral director.	Certification:	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year) 28	Bb. Time of Injury	M 2	8c. Injury : Work? 1 🗆 Ye		2	28d. Describe h				
<u>Ö</u>	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		3 Suicide 6 Could not be determined		c. (Specify)						City or Iow	n, State)			Route Number,
	To the Hospital or within 24 hours afte To the Funeral Director Completely filled in 8	edical	29a. Certifier (Check only one) 2☐ Medical Exami	sician: To the best ner: On the basis o and manner st	r examination	dge, death and/or inv	occurred estigation,	at the time in my opii	, date and p nion, death	place, a occurre	and due to the o	cause(s) a date and	and mann place, and	er as sta d due to	ited. the cause(s)
	To trop	2	29b. Signature and title of certifier	edy Zy	exfect.	I h	140	License			à	/	signed (. :	Pay, Year)
	H		30. Name and address of person who collames Kennedy M.D.					akoma	a Parl	k, M	ID 209	12			
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 8 2	32. Pagistr	ar's Signature	2	alle								

			1 - For State Registrar	State of Mary		artment of F		nd Mental	Hygien	. 0 0 0	05905
	Physici		1. Decedent's Neme (First, Middle, Les Gorman Elbert T	,				2. Dete d Month	De		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	E	4b. City, Town, o	LCA	MP		HARFO	RD
	Funeral Director	N .		x 7. Age (In 83	yrs. last birthday) Yrs.	If Under 1 Yeer Months Days	If Under 2 Hours		of Birth n, <i>Day, Yeer</i> 8 , 19		rthptece (State or Foreign ountry) ryland
	Maryland -f show	tor	Usuel Residence of Decedent 10a. State 10b. County Maryland Harford		c. City, Town or Lo	ecation			·		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	Dire	10e. Street and Number	Apt. E	o in gdon	10f. Zip Code 2100	a			itizen of Whet C	Country?
036	d within 72 hours after death with the Maryland piena. r then "neturel", or Itams 23a or 28a-f show the Maracal Exam we must be rediffed.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever Amed Forces? 1 Mayes 2 No If Yes, Give Year or Detes:				in? (Specify Yes o , Puerto Rican, etc		14. Rece - Am Bleck, Whi	
21215-0036		Completed	15. Decedent's Ed (Specify only highest gred Elementary/Secondary (0-12)	cation le completed) Coltege (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Driver	during most	of working	St	Kind of Business eel nufactu	_
Maryland ?	ba filed tal Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last) Samuel E. Trice	3			Nola		Mars	hall	
	nd 2 s lith ar 27 is r trau		19e. Informant's Name/Reletionship (T. Steve Trice/Son		3608	Woodsdal		r or Rural Route N , Abingdo Dete	n, MD	21009	
Baltimore,	Pa ant ury		20e. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify	Removel from State	Hilltop S	matory or other place Services	Inc. 2	28-06	Tow	son, Ma	ryland
Bal	permit. Departiments Imports any inj		21. Signature of Funeral Service Licens	may	13		bury F	Rd., Abin	gdon,		9
	Physician /Medical Examiner	-e	23a. Part . Enter the disease, or comp shock, or heart failure. List only of the shock of the sh	a. Due to (or as a co	nsequence of):	Squar		Cav		ma	Approximate Interval Between Onset end Death
8760,	icate be executed physician and s the burial-transit	dical Examiner	causé. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a cou	nsequence of):						
.O. Box 6	law requires that the death certific. as been signed by the attending pl 2 should be delached for use as i	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetel death 3	Ectopic pregnancy Other (specify)	/			23d. Dete of de Month	blivery Day Year
Records, P.	w requires tha been signad should ba det	by	Part II. Dther significant conditions co	ntributing to death but no	t resulting in the u	nderlying cause giv	ren in Part I.		Did tobecco		to the cause of death? Probably 4 □Unknown
	The ate h page	Completed						1 V		prior to death?	
of Vital	ding Physician: h. Aftar this cer 'fic funeral diractor,	: To Be	25. Was case referred to pedical examiner? 1 Yes 2 No 27. Mannay of Death		2 ER/Outpatier		er: 4 Nur	sing Home 5 28d Desc	Residence	6 □Other (Spe	ecify)
Division of	or Attendifter deat	Certification:	1 Natural 5 Pending investigation 3 Suicide 4 Homicide 5 Could not be determined	28a. Dete of Injury (Month, Day Yea 28e. Place of Injury - building, etc. (S _i	At home, farm, str	M 1	k?` Yes 2□N	lo 28f. Locati		nd Number or R	dural Route Number,
_		edical C		sicien: To the best of my ner: On the basis of exa and manner stated.							
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	5	to	30. Name and address of person who company the state of t	ompleted cause of death	(Item 23a) (Type,	Print) 8	Lan	1 Stree	t/ 1	Herde	en Thylan
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			1 - For State Registrar	•		nd / Depa		t of H	ealth and I	-	giene (06	05906
			1. Decedent's Name (First, Middle, Last)							2. Date of De Month	eath Day	Year	3. Time of Death
	Physicia /Medic			Joh	n L.	Talbot	t			02	- 20-	06	2:30PM
	Examin		4a. Facility Name (If not institution, give si	reet and numbe	r)		4b. City,	Town, or	Location of Death	h	_	ty of Death	
			Franklin Square	HO501	'fal	Penter	Ros	seda	le		13a,	ltimo	re
	Funeral	11	5. Social Security Number 6. Sex	7. /	Age (In yrs.	last birthday)	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Bi	rth av. Year)	9. Birth	nplace (State or Foreign untry)
	Director		212-52-7915 XX	M 2□F		58 Yrs.	WOTERS		TIOGIG INIII.	Feb. 1	2 , 1948		yĺand
	P		Usual Residence of Decedent		10- 0	h. Tour and							10d. Inside City Limits
	how	_	10a. State 10b. County		100.0	ity, Town or Lo	ocation						y Ves 2 □ No
	Ba-f.e	cto	Maryland N/A				Balt		e				
	or 2	Oire	10e. Street and Number				10f. Zip		01005		10g. Citizen of		
	after death with the Marylan or Items 23e or 28s-f ehow refree caset be notified at	Funeral Director	507 N. East Avenue						21205			USA	
	r des	I PE	11. Marital Status	Was Deceder Armed Force:	nt Ever in U s?	J.S. 13.	Was Deced If Yes, spec	dent of H	ispanic Origin? (S n, Mexican, Puert	pecify Yes or No to Rican, etc.)	o- 14. Ra	ace - Amer ack, White	ncan Indian, e, etc.
98	or It	Ę.	1 Never Married 2 Married	KXYes 2 If Yes, Give			1 🗆 Yes				Spec	ify:	ribi to
1771 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f ehow the Marical Examiner must be notified at	d by	3 ☐ Widowed 🗶☒ Divorced	Year or Dates	[∷] Vie	tnam			***		405 100 4 4		white
<u> </u>	nat inet	ete	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Dece	dent's Usus	nk done	ation du <i>ring</i> most of wor f)	rking	16b. Kind of	dusiness/i	ndustry
22	withir ene. than	Ë	Elementary/Secondary (0-12)	College (1-4o	or 5+)				t agent		Roa1	Esta	to
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and	be for	å	Frederick Talbot	+						Robins			
	s 1 and 2 should be filed within 72 hours Health and Mental Hygiene. Item 27 is marked other than "natural", other traumatic event, the Mudical Exa	ဥ				10h Maili	ing Address	/Stront	and Number or Ru			n State 7	in Code)
Mary	12 sho	7 1	19a. Informant's Name/Relationship (Typ		`					altimor	· ·		
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) all	Depart Import any In		21. Signature of Funeral Service/Liophse	°	_	B	2. Name ar	nd Addres -Hen	ss of Facility SS-Seitz	Funera	1 Home.	Inc.	
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			21. Signature of Funeral Service Conse	ations that caus e cause on each	ed the dea tine.	ith. Do not en	iter the mod	e of dyin	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	int	macr		hem						Onset and Death
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ŏ	th ce endi	ar/	23b. Was decedent pregnant	ic. If yes, outcon 1 ☐ Live birth	ne of pregr 2 Fet	nancy al death 3	□Ectopic p	regnancy	,			ate of deli Month	very Day Year
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Division of Vital Records, P.O. Box	Attending Physician: The law requires that the death certifica in death. •ctor: Atter this certificate hes been signed by the ettending ph by the funeral director, page 2 should be detached for use as the funeral director.	by Physician/Med	9 ☐ Unknown					_			1		
Ś	an the	by	Part II. Other significant conditions con	tributing to death	n but not re	sulting in the i	underlying (ause giv	en in Part I.				the cause of death?
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õ	aw re as be 2 sho	Pet								24a. Wa	s an 24b	. Were au	topsy findings available completion of cause of
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9	ding Phy I. After thi funeral	-	27. Manne Death	28a. Date of In (Month, I	njury Day Yearl	28b. Time	of :	28c. Injur Wor	y at		how injury occi		
io	ndin th.: Aft	읉	1 ✓ atural 5 ☐ Pending 2 ☐ Accident investigation	(NOTALI), I	Day (Gar)	Injury	м		Yes 2 □ No				
S	Attendir death.	₩	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of	Injury - At	home, farm, s	treet, factor	y, office			(Street and Nun	nber or Ru	ral Route Number,
á	s efte	Certification:	4 Hornicide	building,	etc. (Spec	ar y)				City of 10	own, State)		
	ne Hospital or Atti 124 hours efter de 18 Funeral Directo letely filled in by the		29a. Certifier 1 Certifying Phys										
	To the Hospital or Att within 24 hours efter de To the Funeral Direct completely filled in by t	Medicai	(Check only 2 Medical Examinations)	and manner		ation and/or i	nvestigation	n, in my o	pinion, death occi	urred at the time	, date and place	i, and due	to the cause(s)
	To th To th comp	ž	29b. Signature and title of certifier						e number		29d. Date sign		
			Mikhoal	1 /	UD		_ 1	KE:	50000	0	2/2	0/00	,
	177:		-30. Name and address of person who co	mpleted cause of	of death (Ite	em 23a) (Type			.,		- 919	/	
	10.		Dr. Thind 900	O Frank	Win :	Salini	a D	ri ve	DaH	o more	Md 21.	237	7
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Physician (Nedical Examiner) To be to (or as a consequence of): Due to (ä	Per		Scott M.	Cuttle	n				TERSTOWN	V RC)AD - I	PIKES		
Compared to the past 12 months? Compared to the cause of dealth? Compared to the				shock, or heart failure. List only	polications that caus one cause on each	ed the death line.	n. Do not en	ter the m	ode of dying,	such as cardia	c or res	spiratory arre	st,		Interval Between
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			Registrar 1. Decedent's Name (First, Middle, Last)		octimodic of Bodin	2. Date of Death		3. Time of Death
	Physicia /Medic		Anna G. Volz				2006	12:45 A M
}	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea		4c. County of Dea	
			Kris Leigh Assisted Living	la come la má briadh	Gambrills day) If Under 1 Year If Under 24 Hr		Anne Aru	ndel thplace (State or Foreign
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and	×		Usual Residence of Decedent 10a. State 10b. County 10	0c. City, Town	or Location			10d. Inside City Limits
Maryl	-f eho	ō	MD Anne Arundel	Gambri.	119			1 ☐ Yes 2X No
h the	r 28a	rec	10e. Street and Number		10f. Zip Code	10g.	Citizen of What C	ountry?
death with the Maryland	23a o	a D	1032 Annapolis Rd		21054		USA	
o after dea	'naturel', or items 23a or 28a-f ehow Lifeal Examiner must be nutified at	Funeral Director	11. Marital Status 12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ Married 1. ☐ Yes 2 ☐ Married	er in U.S.	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes ☒☒No Specify:	Specify Yes or No- irto Rican, etc.)	14. Race - Am Black, Wh	
5-UUSO 72 hours after	Exar	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:		To tes AANO Specily.			hite
72 h	"naturel", idical Exz	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. C	Decedent's Usual Occupation Give kind of work done during most of will life. DO NOT use retired)	orking 16b	. Kind of Business	s/Industry
within	than	d E	Elementary/Secondary (0-12) Coltege (1-4or 5+)		Administration		Hospital	
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-	Mental arked c	To B	John Volz		Mary	Catherine	Durham	
z shou	and N		19a. Informant's Name/Relationship (Type, Print)	19b. P	Mailing Address (Street and Number or F	Rural Route Number, Cit	ty or Town, State,	Zip Code)
and ;	12 t		Mary Catherine Murphy Niece	12	18 Sunset Lane, An			- Tours Conta
MOFE Pages 1	0 = =		1 Burial 2 TCremation 3 Removal from State	cemetery,	crematory or other place)		.Location - City o Baltimore	1.00
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D BG	Department Important: i any injury c	î l	K. Gregory Jank MO114	48	22 Name and Address of Facility Fink Funeral Home		4 - MD	21061
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do no	426 Crain Hwy SW at enter the mode of dying, such as cardinated as the such as the s	, GIEN BURN ac or respiratory arrest,	ie, MD	21061 Approximate Interval Between
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D. DOX of	been signed by the attending p should be detached for use es	Physician/M	23b. Was decedent pregnant in the past 12 months? 1	Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	elivery Day Year
That	detac		Part II. Other significant conditions contributing to death but n	not resulting in t	the underlying cause given in Part I.	23e. Did tobacc	co use contribute	to the cause of death?
COLDS w requires	n sign ed blu	d by	athits, gout,	den	erta	1 □ Yes	2 No 3 F	Probably 4 Unknown
(D) (C)	S 0	Completed	supperse vasco	ular	cliscase	24a. Was an autopsy performed	prior to	autopsy findings available comptetion of cause of
1 Te	s certificate has b lirector, page 2 s		OF Was seen entered to medical		on Plant 4 D	1 ☐ Yes 2 💢		
VITAL sicien:	s certii lirecto	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outo	Other	eath (Check only one) Home 5 Residence	6 Other (Sp	ecity sisted
o P. O.	erthis ieral c		27. Manner of Death 28a. Date of Injury			28d. Describe how i		Facility
ng in	oath. or: Aft he fur	atlo	2 Accident investigation	,	M 1 Yes 2 No			
DIVISION OF VITA	after de Directo d in by ti	ertification	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (- At home, farr 'Specify)	n, street, factory, office	28f. Location (Stree City or Town, S		Ru <i>ral R</i> oute Number,
Mospite	within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of n the basis of examiner: On the basis of examiner states	xamination and				
To the	within To the	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Mor	nth. Day, Year)
)	i		Medicano		00061864	5	474/3	006
	K		30. Name and address of person who completed cause of deal 8001 Vetturns Highway	th (Item 23a) (T	Type, Print) Millersville	ing on	1108	
3	Sta Registr		31. Date filed (Month, Day, Year) - 32. Poistrar's	Signature	Loude	-,		

			1 - For State Registrar	State of Mar		artment of I rtificate of			giene	6 05910
	Physic	ian	Decedent's Name (First, Middle, L	ast)				2. Date of De Month	Day ,	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, gi	Ve street and number)		4b. City, Town, o	or Location of Death	02	34 a	006 d
		ight _{to}		: Renaisance		Pari	KUILLE		Back	more County
46	Funeral Director		5. Social Security Number J6. 558-20-6333	Sex 7. Age (1□XM 2□ F	In yrs. last birthday, Yrs.	Months Days		8. Date of Bir (Month, Da 0ct. 31	rth ay, Year) 1017	9. Birthplace (State or Foreign Nebraska
À.	Ö		Usual Residence of Decedent 10a, State 10b, County					000.01	., 1317	
	Maryla f shov	jo	Maryland N/A		oc. City, Town or Le	timore				10d. Inside City Limits 1 √2 Yes 2 □ No
	or 28e	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wi	
	ath wi	raic	4914 LaSalle Av				206			ed States
21215-0036	72 hours after death with the Maryland *natural', or Itame 23a or 28e-f show salcal Evandrat must be coulled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3/2 Widowed 4 □ Divorced	12. Was Decedent Ev Anned Forces? 1 [2] Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. White
15-0	n 72 h natu edical	ietec	15. Decedent's E (Specify only highest gi	ducation ade completed)	(Give	dent's Usual Occur kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Bus	iness/Industry
212	filed within Hygiene. ther than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ervice Ma	,		Automot	cive Dealer
pu		Be	17. Father's Name (First, Middle, Las John Vonders						, Maiden Surname	•
Maryland	Mer Mer arke	2	19a. Informant's Name/Relationship		19h Maili	ng Addrose (Stroot	Carri		ckminster	
	12 ha ra	8	Mr. Ray A. Vonder			Garland			Hall, Mar	
Baltimore,	of of		20a. Method of Disposition 1 Disposition 3 [Removal from State	20b. Place of Dispo cemetery, crei	matory or other pla	ice)	Date		ity or Town, State
Him			4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	(y)	00	eart of C 2. Name and Addre	Jesus 2/28	3/2006		, Maryland
Ba	permit. Departr Imports any inju		1 dec	Michael E.	Canapp 2		J. Ruck,	Inc.	5305 Har Baltimor	ford Road e, MD 21214
w.			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the	e death. Do not en	er the mode of dyl	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. End S	tage	Alzhei	meris T	Sispus	2	Onset and Death
**	Examiner		Consequently that are differen	b	onsequence or);					
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onequation of);					
<u>,</u>	be executed sicien and burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):					
8760	ate be ex hysicien the buria	cai		d						
9	ertifica ding ph	/Med	IF FEMALE:	220 16 100 100 100 100						
P.O. Box	res that the death certificate signed by the attending phys be detached for use as the	Physician/Medicai	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date Monti	,
	res tha igned be del	by	Part II. Other significant conditions	contributing to death but r	not resulting in the u	nderlying cause giv	ven in Part I.			oute to the cause of death?
Sorc	v requi	Completed								Probably 4 📈 Thknown
Re	The had age	omp							osy prie	ere autopsy findings available or to completion of cause of ath?
ital	certifical rector, p	Be C	25. Was case referred to medical examiner?				26. Place of Death	1 ☐ Yes	-	Yes 2 No
of \	Physician; this certific al director,	မ	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital:	2 ER/Outpatier	I JUDA			dence 6 Other	
ion	Attending I r death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	Wor	ry at rk? ∣Yes 2 □ No	28d. Describe I	now injury occurred	1
Division of Vital Records,	after death Director: In by the	Certification:	3 Suicide 6 Could not to determined		- At home, farm, str Specify)	eet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific ormpletely filled in by the funeral director, completely filled in by the funeral director,	edical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of n niner: On the basis of ex and manner stated	amination and/or in	occurred at the tirvestigation, in my o	me, date and place, opinion, death occurr	and due to the e	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Month, Day, Year)
	. 1		a mon		uci	1728	5646		Februar	4 27, 2006
Ì	010		30. Name and address of person who	completed cause of deat		Print)			2123	
	Sta	100	31. Date filed (Month, Day, Year)	32. Pegistrar's	Signature	. M a	12.	1 2 2 1 2		
DH	Registr MH 17 Rev 1/20	100	FEB 2.8.2	006 Lineur	Di Ag	and s				

			1 - For State Registrar	State of M	aryland		artmen <i>rtificate</i>					iene	5 ()5911
	Physici	an	1. Decedent's Name (First, Middle, La								2. Date of Dea		Year	3. Time of Death
	/Medic		John Ernest		ossum,	Sr.	,				Februar	cy 25, 2	2006	10:47 P ^M
7	Examir	er	4a. Facility Name (If not institution, gi	· ·			4b. City,	Town, or	Location of	of Death		4c. County	of Death	
			1801 Philadelph 5. Social Security Number 6.	ia Road	e (In yrs. las	et hirthday	Jor If Under	ppa	If Under	24 Hrs.	9 Date of Birth	Harfo		Jane (Ctata - Farris
н	Funeral Director		214-24-3302	Sex 7. Ag 1 A M 2 ☐ F	78	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Jan. 19	Year) 1928	Cour	place (State or Foreign ptry) Vland
	P.		Usual Residence of Decedent						J			, 1520	1 10.1	<u>Jacobia</u>
	the Marylar 28e-f show	_	10a. State 10b. County		10c. City,	Town or Lo	ocation						1	Od. Inside City Limits
	Be-f	Director	Maryland Harford	d	Jopp	a								1 ☐ Yes 2 ZNo
	with t	급	10e. Street and Number 1801 Philadelph:	ia Poad			10f. Zip				1	0g. Citizen of W	hat Cour	itry?
	ns 23e	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13.			spanic Orig	gin? (Spe	cify Yes or No-	USA 14 Bace	- Americ	an Indian.
9	after or iten		1 Never Married 2 Married	Armed Forces?	No					, Puèrto F	cify Yes or No- Rican, etc.)		, White,	
5-0036	hours after death with the Maryland turel', or items 23e or 28e-1 show a Examinar must be notified at	d by	3 ☐ Widowed 4 ☐ Voivorced	If Yes, Give Year or Dates:	WW II		1 ☐ Yes 2	2 LL N 0	Specify:			Specify:	Wh	ite
5-	"net	Completed	15. Decedent's E (Specify only highest gr			16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa	ation during most	t of workin	ng	16b. Kind of Bus	siness/Ind	dustry
2121	within ene. then "	dmc	Elementary/Secondary (0-12)	College (1-4or								** G G-	01622	mont
	Hygi Other ent, I	Be C	12. Tather's Name (First, Middle, Las.	")		Sneet	. Meta	II ME			(First, Middle, M	U.S. GC Maiden Sumame		menc
lan	ould be Mental warked o	To B	Harry Ernes	t Van	Rossu	m			Lena		u/k	F	ury	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. item 27 Is marked other then "neturel", or items 23e or 28e-f show other treumetic event, If a Medical Examinar must be notified at	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	or or Rural	Route Number	City or Town, S	State, Zip	Code)
_	and 2 lealth m 27 I		Joanna M. Procto	c - Daughte	er	1801	Phila	del	hia I	Road,	Joppa,	MD 210	85	
Baltimore	0 = 5		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State	20b. Plac	se of Dispo netery, crei	sition (Nam natory or of	ne of ther place	θ)	Di	ate	20c. Location - (City or To	wn, State
ţ	permit. Pag Department Importent: eny injury o		' 4 □Donation 5 □ Other (Speci	• •	Gard		of Fai				′06 I			
Bai	permit. Departrimporte eny inju		21. Signature of Funeral Service Lice	Mara la			2. Name and			IAIC	Comas F			
	*		23a. Part1. Enter the disease, or con	polications that caused	the death.	Do not ent	er the mode	OKES e of dvino	bury	Roac cardiac or	Abino	don, Ma	ryla	nd 21009 Approximate
	Physician		Immediate Cause (Final	one cause on each ii	ne.		Dise					,,,,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. CoRol			2700	713						
L	Examiner		Sequentially list conditions	CHRON	10	OBST	RUCTI	VE	PUL	MON	SARY D	VSEAST		
w/	sit sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as										
1	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	o o o o o		ТНУ						-	
8760	eath certificate be ex attending physician for use as the burial	dicai E			, , , , , , , , , , , , , , , , , , , ,									
9	g phy as the	edic		_ u.										
Вох	h cert endin	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pre					23d. Date	of delive	ry
	ne deat the att hed for	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at			Other (spe					Mont	th	Day Year
P.0	that the deed by the detached	Phy	9 Unknown				- max							
ds,	es ign be	by	Part II. Other significant conditions	contributing to death b	ut not resultii	ng in the ui	nderlying ca	luse give	n in Part I.			_	oute to th	e cause of death?
Ö	w requir been s should	etec								_				,
Vital Record	ne lav s has ge 2 s	Completed by									24a. Was ar autopsy perform	24b. W	ere autor ior to con eath?	osy findings available of cause of
E		_	25. Was case referred to medical			_			00.51	(D	1 ☐ Yes 2	₩No 1.		2□ No
5	Physicien: this certific ral director,	To B	examiner?	Hospital: 1 ☐ Inpatie	nt 2 PA	VOutpatien	t 3 DO	Othe			Check on one		(Consit.	
			27. Manner of Death	28a. Date of Inju. (Month, Day		Bb. Time of Injury		Bc. Injury Work			8d. Describe ho			
ior	ttending Pt death. ctor: After th y the funeral	atio	1 ☑Natural 5 ☐ Pending investigatio	n	/ rear/	injury	М		es 2□N	10				
Division	I or Attencafter death Director: I in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ury - At home c. (Specify)	e, farm, str	eet, factory,	office		28	8f. Location (Str City or Town	eet and Number State)	or Rural	Route Number,
	pitel (urs al srel D		20a Canific											
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	edical	29a. Certifier 1 ✓ Certifying Pt (Check only 2 ☐ Medical Examone)	nysician: To the best of miner: On the basis of and manner sta	examination	idge, death and/or inv	occurred a restigation,	it the time in my op	e, date and inion, deatl	í place, ar h occurred	nd due to the ca d at the time, da	use(s) and man te and place, an	ner as sta id due to	ated. the cause(s)
	o the		29b. Signature and title of certifier	and mainler Sta	nou.		29c.	License	number		29	d. Date signed	(Month, E	Day, Year)
	- 5 - 0		>1/1/0 linus	- ON			1	71	545	.1		•		
	2011	F	30. Name and address of person wh	empleted cause of d	eath (Item 23	Ba) (Type,	Print)	74	2 12	_	110	- Ji CVAICY	9C ()	2006 YLAND 21014
	7		SHED F. MAHMOO	MD. 4-	BNO	RTH	AVEN	リリモ	Sur	TE 3	or BE	L AIR	MAR	YCAND 21014
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	34								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26 Day **Physician** Month 2006 Guy Edward Wine Feb. 5:15 p /Medical 4a Facility Name (If not institution, give street and number) 2834 Tracey Mill Rd. 4b. City, Town, or Location of Death Examiner 4c. County of Death Manchester Carroll 5. Social Security Number 7. Age (In yrs. last birthday) 86 Yrs. 8. Date of Birth (Month Day April 1 **Funeral** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 219-36-0421 Year) 1919 1-15 M 2□F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic event, Tra Mudical Exam set must be motified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll Manchester 1 ☐ Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 2834 Tracey Mill Rd. 21102 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: by Specify: White 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward M. Wine Adelia May Hesson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Wine Myers - daughter 3704 Schalk Rd. #1, Manchester, Md. 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State John Luther Miller Cem. March 1,2006 ^¹ 4 □ Donation 5 □ Other (Specify) Westminster, Md. 21. Signature of Funeral Service Licensee E22 Name and Address of Facility 3296 Charmil Dr. Chapel P.A. Manchester, Hith hellis Md. 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) certensian Unkreses /Medical Due or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit attending physician for use as the buria Division of Vital Records, P.O. Box 68760 erelie lar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deal
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the detached 9 Unknown certificate has been signed by irector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 Yes 2 No To the Hospitel or Attanding Physician: within 24 hours after death.

To the Funaral Diractor: After this certifics 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No investigation M 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number D0033165 2/27/2006 ZIII Hansver Pike Hampstead, MD ddress of person who completed cause of death (Item 23a) (Type, Print) Steven Shatter $M \cdot D$ 31. Date filed (Month, Day, Year) 3 egistrar's Signature State 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 11 15 05012

			1 - For State Registrar		C	ertificate of l	Death	Reg	g. No.	o ubalo
П	Physici	an	1. Decedent's Name (First, Middle, L	ast)				2. Date of Death Month		3. Time of Death
	/Medi		CHARLES H. WILL					FEBRUAR	Y 27, 2	1:30 A M
	Examir	ner	4a. Facility Name (If not institution, g	· ·			Location of Death		4c. County o	
	Funeral		MARINER HEALTH 5. Social Security Number 6.		(In yrs. last birthda	GLEN BU		8. Date of Birth	ANNE	ARUNDEL 9. Birthplace (State or Foreign
	Director		219.18.6604 Usual Residence of Decedent	1 M 2 F	81 Yrs.	Months Days	Hours Min.	OCT 18,		Country) MD
	death with the Maryland ms 23a or 28a-f ehow rmust be notified at		10a. State 10b. County		10c. City, Town or	Location			·	10d. Inside City Limits
	B Mar	cto	MD ANNE	ARUNDEL	GLEN E	URNIE				1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code		109	g. Citizen of W	hat Country?
	s 23s		617 CAROLINE RD			210				SA
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces?		 Was Decedent of Hi If Yes, specify Cuba 	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc.
0000	el', or	þ	₩Widowed 4 Divorced	1 XIX es 2 □ N If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specity:	WHITE
o O	be filed within 72 hours after death with the Maryla ital Hygiene. Id other than "naturel", or Items 23e or 28e-f ehov event, the Madical Examinar must be notified at	Completed	15. Decedent's I	Education rade completed)	(Gi	cedent's Usual Occupa	turing most of work	ina 16	5b. Kind of Bus	siness/Industry
7	within ine. ihen "	mpi	Elementary/Secondary (0-12)	College (1-4or 5-	life	. DO NOT use retired)	9		
V	be filed v Ital Hygie Id other t	e Co	12 17. Father's Name (First, Middle, Las	6	1	EACHER	18 Mother's Name	e (First, Middle, Ma		UNTY SCHOOLS
and and	2 should be filed volume and Mental Hygie lis marked other treumatic event, the	To Be	WILLIAM R. WILL						nden Samame	,
a Z	should I and Men marke umatic	-	19a. Informant's Name/Relationship		19b. Ma	iling Address (Street a		DAUMANN al Route Number, (City or Town, S	State, Zip Code)
Ž	5 # 2 F		SCOTT WILLIAMS	SON	61	7 CAROLINE	RD. GLE	N BURNIE,	MD 21	061
9	of Head Item		20a. Method of Disposition	Removal from State	20b. Place of Dis cemetery, cr	position (Name of rematory or other place		Date 20	c. Location - C	City or Town, State
	Peges tment of tent: if it		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec			CREMATORY			BALTIMO	RE, MD
D D	permit. Peges Depertment of i Importent: if its eny injury or o		21. Signature of Funeral Service Lice			INK FUNERA				
H	- 10 -		23a. Part . Enter the disease, or-cor	nplications that caused	the death. Do not e	26 CRAIN H	WY SW GL	EN BURNIE or respiratory arres	, MD 2	Approximate
	Physician		shock, or heart failure. List ont	y one cause on each line	e. 2	. 1				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a	consequence of):	in tume	37			months
	Examiner		Sequentially list conditions.	b						
-	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
•	xecut and al-tran	хап	that initiated events resulting in death) Last	cDue to (or as a	consequence of):					
, O	srtificate be executed ing physician and e as the burial-transit		(d.						
0	rtificat g phy as th	Medical	15554415							
Š	th cer tendir or use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		☐Ectopic pregnancy				of delivery
	ie dea the at hed fo	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at t 9☐ Unknown		Other (specify)			Mont	h Day Year
	that the	Ph	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause give	n in Part I.	23e. Did toba	cco use contrib	oute to the cause of death?
Ŝ	uires sign id be	d by	Myperternia	n	,				_	Probably 4 Onknown
2	w req	lete	Dicheter	Melitus	time (24a. Was an	24b. W	ere autopsy findings available
ב	The ia	Completed	2100 (3		11			autopsy performe	d? pri	or to completion of cause of ath?
	ien: rtifice ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Death	1 Yes 25 (Check only one)	2 /No 1 [☐Yes 2☐No
-	hysic his ce il dire	70	1 Yes 2 No	J	t 2 ER/Outpati	ent 3 DOA Othe	4 Nursing Ho	me 5 Residenc	ce 6 Other	(Specify)
	ling P	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Work		28d. Describe how	injury occurred	d
2	death death stor: / the f	icat	2 Accident investigation 3 Suicide 6 Could not I	De Blace of Injur	y - At home, farm, s		′es 2 No	20f Location (Ctra	-4d & (h	or Rural Route Number,
2	ital or A rs efter rai Dire led in by	Certification:	4 Homicide determined	building, etc.	(Specify)	treet, lactory, office		City or Town, S		or Aurai Aoule Number,
:	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 54 hours eiter death. To the Funeral Director: Attenthis certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edicai	29a. Certifier 1 Tartifying P (Check only one) 2 Madical Exa	hysician: To the best of minar: On the basis of e and manner state	examination and/or i	ath occurred at the time investigation, in my op	e, date and place, a inion, death occurr	and due to the caused at the time, date	se(s) and man	ner as stated. d due to the cause(s)
	Veith To t	Σ	29b. Signature and title of certifier	Joney M.	Q	29c. License	15204	Fe	borun	(Month, Day, Year) 27, 2006
	(i)		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	SPIN 325	MOUPITAL	DRIVE	Suit	€ 208
	· ·		DR. O CHAVE:	J	'e Signatura	grien &	SURNIE,	WD 51	6-61	
	Sta Registr		FEB 2 8		's Signature	March 8				
DHA.	H 17 Rev 1/20		1 1 2 0	TOOL STATE	100 Mg 100					

For	Unpend item#23a,PT State o	27,28a-f, perMF, 9855,5/26/06 TT Maryland Department of Health and	Mental Hygiene	759
State Registrar		Certificate of Death	Reg. No.	UDJIB
Decedent's Name	(First, Middle, Last)		2. Date of Death	3. Time of Death

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 Is marked other then "neturel", or Items 23a or 28s-f show any injury or other traumatic event. The Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	= State Registrar			Cert	tificate of l	Death			Reg.	No.	U	UU	111	
	1. Decedent's Name (First, Middle, Last,)						2. Date of D				3. Ti	me of Death	
1	Lamar	D	1.	Mi	illiams			Month		Day	Year			М
1	4a. Facility Name (If not institution, give					. 1		Februa			006	5:1	9 P	
	· · · · · · · · · · · · · · · · · · ·				4b. City, Town, or		or Death			4c. County		1		
	University of Mary				Balti						N/A			
	5. Social Security Number 6. Sec	K 7. A]M 2□F	ge (In yrs. last bir	- / -	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	B. Date of Bi	rth ay, Yea	ar)	9. Birth Cor	nplace (S untry)	tate or Fore	ign
ļ	213-76-6760	3 2	43	Yrs.				(Month, D 8-4-	62			N	1d.	
	Usual Residence of Decedent		T 12 2 2 2											
.	10a. State 10b. County		10c. City, Tow										ide City Limi	
	Md. NA		Ba	ltim	nore							1 💆	Yes 2□N	10
2	10e. Street and Number				10f. Zip Code				10g. (Citizen of V	Vhat Co	untry?		
,	3504 W. Franklin	Stroot			2122	00				TICA				
5		12. Was Deceden	t Ever in U.S.	13 W		***	iain? (Soc	ocifu Vos or N	0-	USA 14 Bac	o - Amor	ican India		
י עויפושו חוופריטו	1 ☑ Never Married 2 ☐ Married	Armed Forces	?	lf '	as Decedent of Hi Yes, specify Cuba	n, Mexica	n. Puerto	Rican, etc.)	•		k, White		шт,	
2	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:		1(□Yes 2X No	Specify:				Specify	: B1	lack		
;														
nandina	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a.	(Give kı	ent's Usual Occupa and of work done of	<i>turina</i> mos	t of worki	ng	16b.	. Kind of Bu	isiness/l	ndustry		
-	Elementary/Secondary (0-12)	College (1-4or	5+)	lite. Do	O NOT use retired)								
3	llth grade			Disa	bled					NA				
3	17. Father's Name (First, Middle, Last)					18. Moth	er's Name	(First, Middle	, Maid	en Sumam	ө)			
	Troy N	athaniel	Bernard	Wi	lliams	Jo	русе	M	ari	е	Mur	ray		
	19a. Informant's Name/Relationship (Type		19b	. Mailing	Address (Street a	and Numb	er or Rura	I Route Numb	er, Cit	y or Town.	State. Z	ip Code)		
j	Joyce M. Williams				4 W. Fra							id.	21229	
1	20a. Method of Disposition		20b. Place of		tion (Name of	147		ate	_				10	-
	1 ☐ Burial 2√ Cremation 3 ☐ B	emoval from State		y, crema	atory or other plac	9)		410	200.	Location -	City or I	own, Sta	ii.	
	4 ☐ Donation 5 ☐ Other (Specify)		_	nmou	int Cem.	i i	2-28	3-06	В	altim	ore,	Md.		
	21. Signature of Funeral Service License	90		22.	Name and Addres	s of Facili	y	Ba		more,			202	
	I lados	W	كسعس	M	larch F.H	. Eas	t	1101	E.	Nort	h Av	e.		
1	23a. Part 1. Enter the disease, or compli	cations that cause	d the death. Do n	not enter	the mode of dvine	such as	cardiac o	r resouratory a	rrest	-		Approx	kimate	
	shock, or heart failure. List only on Immediate Cause (Final	e cause on each i	ine.						,			Interva	al Between and Death	
	disease or condition resulting in death)	Respirate	ory failure	e wit	h pneumoni	a and	sepsi.	S						
	resulting in death)		a consequence											
	Sequentially list conditions, b													
t	If any, leading to immediate	Due to (ur as	à consequence d	λij.										
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events													
	resulting in death) Last	Due to (or as	a consequence	of):										-
1														
	d	• —												
	IF FEMALE:					25 S								
	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1□Live birth	of pregnancy 2 Petal death	3 □E	ctopic pregnancy					23d. Dat		-		
	1 ☐ Yes 2 ☐ No	4☐Pregnant a	t time of death		Other (specify)					Mor	nth	Day	Year	
	9 Unknown	9□ Unknown					_							
	Part II. Other significant conditions con	tributing to death t	out not resulting in	the und	erlying cause give	n in Part I.		23e. Did t	obacco	use contr	bute to	he cause	of death?	
	remote gunshot wounds							10	Yes	2□No	3 ☐ Pro	bably 4	4 🛣 Unknow	m
ľ			-							-			-	_
	intravenous drug use w	ith complic	cations; si	ıckle	cell dise	ase		24a. Was	psy	24b. V	Vere aut	opsy findi	ings availab	le
ı	with complications								rmed? 2 □ N	ď	e th?	2□ No		
1	25. Was case referred to medical					26, Place	of Death	/Check only	-		1			
	examiner? 1 XYes 2 No Ho	ospital:	ent 2X ER/Out	nations	3 DOA Othe			4.0		6 004	r (C-	4.1		
1	27. Manner of Death	28a. Date of Inju	rv 28b. T		3 DOA	4 🗆 140		ne 5 Resi				iy)		_
1	1 ☐Natural 5 ☐ Pending	(Month, Da	y Year) In	ijury	28c. Injury Work				11]	in and and an in	<i>,</i>			
1	2 Accident investigation 3 Suicide 6 X Could not be	Fnd 2/12/2		5:10	P	′es 2 X		unk						
	4 Homicide determined	28e. Place of In building, et	jury - At home, far tc. <i>(Specify)</i>	m, stree	t, factory, office		2	Bf. Location (. City or To	Street a wn, Sta	and Number	or or Run	al Route	Number, Street	
L		Found at	universit	y spe	ecialty hos	spital	I	Baltimore	e.MD	.001	J. UN	artes	screet	-
1	29a. Certifier 1 ☐ Certifying Phys	icien: To the best	of my knowledge.	death o	ccurred at the time	a data an	d place a	nd due to the	causol	(c) and mo	nner as s	stated.		
1	one) 2 Medical Examin	er. On the basis of and manner st	i examination and	vor inves	stigation, in my op	inion, deal	h occurre	d at the time,	date a	nd place, a	nd due t	o the cau	ise(s)	
-	29b. Signature and title of certifier				29c. License	number			29d. D	ate signed	(Month	Day. Ye.	ar)	
	han soi	m.v			ļ					_		-		
-					0.C.	M.E.			Feb	ruary	13,	200	06	
1	30. Name and address of person who cor													
	LING LI,			111	Penn Str	eet,	Balt	imore,	Ma	rylan	d 21	.201		
	31. Date filed (Month, Day, Year)		ar's Signature	e e										

State

Registrar

FEB 2 8 2006

3. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** George Sabastian Wehn, Sr. $\rho_{\rm M}$ 22 2006 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 216 20 4884 Director 78 1927 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Director Marvland Somerset Princess Anne 1 ☐ Yes 2 K No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? U.S. 27311 Mt. Vernon Road 21853 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Baltimore City 8th and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Carrie Butcher Thomas Alexander Wehn ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: If Item 27 ie any njury or other treu once. Ferndale, Maryland 21061 Heidi Michael / Daughter 108 - 2nd Avenue South Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Eldridge, Maryland Meadowridge Mem. Park 2/28/2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 ramerous 23a. Part1. Enter the dise se, shock, or heart failure. List plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical or as a consequence of); Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the deeth certificate be executed use as the burial-transit Division of Vital Records, P.O. Box 68760, 🔨 resulting in death) Last Due to (or a a Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 Probably 4 Unknown been : 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an hes certificate 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death Check only one 1 Yes 2 No Hospital 1 npatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA this 27. Magner of D. 1. A. Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After or Attending 5 Pending 1 Natural 2 Accident death. investigation 1 ☐ Yes 2 ☐ No s after death 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier M ss of person who completed cause of death (Item 23a) (Type, Print)-31. Pate filed (Month, Day, Year) State Registrar

			1 - For State of Maryland /		artment rtificate				Re	g. No.	5 ()5917
	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Helga N. Wilke						Date of Death Month WWW.		Year 006	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Keswick				Location of i			4c. County		
	Funeral Director		5. Social Security Number 334-26-7403 G. Sex 1 □ M 2 ▼ F 7. Age (In yrs. last bite 2 ▼ F) 99 Usual Residence of Decedent	irthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours		ate of Birth Month Cay, Y 25,	⁷ 1906	9. Birthp Den	place (State or Foreign ntry) Mark
	a-f show	ctor	10a. State 10b. County 10c. City, Tov		more						1	0d. Inside City Limits Y☐ Yes 2☐ No
	3a or 28	i Director	10e. Street and Number 700 W. 40th Street		10f. Zip	Code 21 21	1		10	og. Citizen of V		ntry?
9036	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or items 23a or 28a-f show event, I're Modical Evertires must be notified at	d by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedif Yes, spec		spanic Origin, Mexican, I	n? (Specify Puerto Ricar		Specify	k, White,	hite
21215-0036		Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. i	dent's Usua kind of wor DO NOT us OMEMA	k doné d e retired;	uring most o				home	dustry
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than traumatic evant, Ine Ma	To Be	17. Father's Name (First, Middle, Last) Niels N. Nielsen				Anr	na	C.	Maiden Sumam	er	
	and ealt nar		M. Daniel Lane-son	560	7 Roxl	oury			more,		209	
Baltimore,			1 □ Burial 2 □ Cremation 3 □ Hemoval from State 1 □ Donation 5 □ Other (Specify) Hillt	ary, crar Cop	natory or ot Servi	her place Ce C	orp.	2/27/	06	Towso	n, M	D
Ball	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Societicensee William G. Dat				Rd.,			1 Funer 21204		ome, Inc.
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a.				g, such as ca	ardiac or res	piratory arre	st,		Approximate Interval Between Onset and Death Tears
8760,	Examine price of the price of t	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence	of).								
.O. Box 6	that the death certific ed by the attending p detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		Ectopic pre					23d. Dat Mor	e of delive	ery Day Year
ο.	juires that t n signed by ud be deta	þ	Part II. Other significant conditions contributing to death but not resulting Cardunascular dusease unit			-			23e. Did tob	. /	ibute to ti 3 ☐ Prot	he cause of death?
Records,		Completed	Pressure around	-				_	24a. Was an autopsy perform 1 □ Yes 2	heds c	Vere auto prior to co leath?	psy findings available mpletion of cause of
n of Vital	ding Physicien: The h. h. After this certificate ha funeral director, page	To Be	1 Natural 5 Pending (Month, Day Year)	utpatier Time of Injury	f 28	Bc. Injury Work	at ?	sing Home 28d.		nce 6 Other		ý)
Division	or Attend after death Director: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, 1 building, etc. (Specify)	arm, str	M reet, factory		∕es 2⊡No	28f. L	Location (Str City or Town		er or Rura	al Route Number,
_	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medicai Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the basis of examination a and manner stated.	ge, deatl .nd/or in	h occurred a vestigation,	at the tim	e, date and pinion, death	place, and o	due to the ca t the time, da	use(s) and ma ite and place, a	nner as s and due to	tated. the cause(s)
)	To the vithin To the comple	Me	29b. Signature and title of certifier Mabelle The Gregor MD			License	number 57			od. Date signed		Day, Year) 4,2006
	10		30. Name and address of person who completed cause of death (Item 23a) TIPBELLE TAESREGOR, 700 W.	40 4	th st	REED	, BA	LTIO				
	Sta Registi		31. Date filed (Month, Day, Year) September 1997 32 Registrar's Signature	A G	ack!							

Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu ë.

6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February D58646 monic 27,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkville MN 21234 walther Boulevard An no Monias 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 2 8 2006

State Registrar

Medical

wanded

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Myrtle C. White 2:40 a Feb 22, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel Manner Health of North Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Director 215-40-8792 Aug 3, 1923 Maryland Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f ahow the Medical Examiner must be notified at Director Marvland Anne Arundel Glen Burnie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8078 Solley Road 21060 U.S.A. filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ģ Black 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lighty or other traumatic avent, 800.8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Bouyer Carvella Cephus 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eloise White Daughter 8078 Solley Road Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/27/06 Pasadena, Md. Mt. Zion Church Cemetery 21. Sign vare / uneral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part: Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) evelvovamular Acciden **Physician** Day /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death ned by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign 3 be duan Coi 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1 Yes 2 - NO Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nersing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 2Bb. Time of Injury Medical Certification: 27. Manner of Death 2Bd. Describe how injury occurred 5 Pending investigation 1 Aatural death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 3 T Suicide 6 ☐ Could not be 2Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Learnitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier Cenual W Altendery boctor D21684 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITCHUS GWY PASADENA C-V. CYRIAC, 4-0 8021 31. Date filed (Month, Day, Year) 32. Refistrar's Signature State Registrar

Registrar DHMH 17 Rev 1/2001

State

FRANCIS

31. Date filed (Month, Day, Year)

KHUO

MD

32. Registrar's Signature

Garde

200 MEMORIALAVE

WESTMINSTER, MD 2115

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARFOLL HOSPITAL CENTER

		4	1 - State Registrar		•	Certificate of	Death	Re	2 UUD	03921
	Physicia	an	1. Decedent's Name (First, Middle		12 94 0			2. Date of Deat Month	h Day Year	3. Time of Death
	/Medic		JAMES	D WILL				2 6	4 2006	10:50 AM
	Examin	er	4a. Facility Name (If not institution,	Give street and number)	BAUTO-	4b. City, Town,	or Location of Death	021223	4c. County of Dea	th
	Funeral Director		5. Social Security Number 577 822 4574		(In yrs. last b	-	r If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign ountry)
7	D		Usual Residence of Decedent 10a, State 10b, County		10c City Toy	wn or Location				10d. Inside City Limits
	show	2				imore				1 ∑Yes 2 □ No
-	28e-1	Director	MD NA 10e, Street and Number		Daic	10f. Zip Code		10	Og. Citizen of What Co	ountry?
Į.	3e or		2325 Hollins	Street Apt	309		21223		U.S.A	•
1	ms 2	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?			Hispanic Origin? (Spe ban, Mexican, Puerto	cify Yes or No-	14. Race - Ame	
3	permit. Pages 1 and 2 should be lied within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Be promotents if time X7 is marked other than "netural", or items 23e or 28e-f show any injury or other treumetic event, the Medical Examinal must be inclined at once.	by Fu	1 ☐ Never Married 2 ☐ Marri XXWidowed 4 ☐ Divorced		lo	1 ☐ Yes 2 💢 No		nican, etc.)	Specify: E	Black
	72 h netu	etec	15. Decedent (Specify only highes	s Education t grade completed)	168	a. Decedent's Usual Occu (Give kind of work done	e durina most of workii	ng	16b. Kind of Business	/Industry
J	han.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT use retir	Trainer	Ι.)istrict	Governmen
1 -	Hygie Hygie ther t nt, in		12th grade 17. Father's Name (First, Middle, 1	na ast)		HOLSE	18. Mother's Name			0010211111011
	d be antal lited o	o Be	Edward Gray				Evelyn N			
•	shoul nd Me mark imeti	2	19a. Informant's Name/Relationsh	ip (Type, Print)	19	b. Mailing Address (Stree				Zip Code) 20002
_ (and 2 ealth a n 27 is ner treu		Latia Brown-I	aughter						ington, D
, כ	of Hei		20a. Method of Disposition			of Disposition (Name of ery, crematory or other pl.			20c. Location - City or	
	Pages nent of I ant: If its ary or o		1 🔀 Burial 2 □ Cremation 1 4 □ Donation 5 □ Other (Sp			us Memori		3/1/06	Arbutus,	Mđ
	permit. Departn Importe any inju		21. Signature of Funeral Service I	icensee A	MH	22. Name and Add 4356 F 4368 Was	ress of Facility H West ash Ave,	Baltin	more, Md	21215
	1	1	23a. Pm11. Enter the disease, or lock, or heart failure. List	complications that caused	the leath. Do	not enter the mode of dy	ring, such as cardiac o	r respiratory arre	est,	Approximate Interval Between
P	hysician		Immediate Cause (Final divase or condition	LiVE	2	cirrho	SUS			Onset and Death
	/Medical	Ų	resulting in death)	Due to (or as a	consequence	of):				
, i	Examiner		Sequentially list conditions.	b. AS	ate)				
7	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that interest and the cause)	Due to for as a	a consequence	of):				
	and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a	a consequence	of):				
	be e sician buria									
	ficate p physics the	Medicai		d.			•			
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within £4 hours after death. To the £4 hours after death. To the £4 hours after death. To the £4 hours after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deat	h 3 Ectopic pregnan 5 Other (specify)	су		23d. Date of de Month	livery Day Year
	that hed by deta	by Pr	Part II. Other significant condition	ns contributing to death bu	ut not resulting	in the underlying cause g	iven in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
3	quire; in sign						, , , , , , , , , , , , , , , , , , , ,	1 ☐ Ye	s 2□No 3□P	robably 4 Dunknown
	aw re	Completed						24a. Was ar	24b. Were a	utopsy findings available
	sicien: The law certificate has b irector, page 2 s	mo						autops perform 1 Yes 2	ned? death?	completion of cause of
וומ	len: rtifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Death			
-	Physic this ce al direc	To	1 ☐ Yes 2 No	Hospital: 1 Impatie	nt 2 ERVO	utpatient 3 DOA	ther: 4 Nursing Hor	ne 5 🗆 Reside	nce 6 Other (Spe	ocify)
	To the Hospitel or Attending Physicien: The within 24 Hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page		27. Mann Death Dea	ation			ury at ork? □ Yes 2 □ No	28d. Describe ho	w injury occurred	
	tel or Att	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	of be ned 28e. Place of Inju- building, etc	iry - At home, f :. (Specify)	arm, street, factory, office	2	28f. Location (Str City or Town	reet and Number or R , State)	ura! Route Number,
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifyin (Check only one) 2 Medical I	g Physician: To the best of Examiner: On the basis of and manner sta	examination a	ge, death occurred at the nd/or investigation, in my	time, date and place, a opinion, death occurre	and due to the ca ed at the time, da	use(s) and manner a ate and place, and du	s stated. e to the cause(s)
,	To t To t	Σ	29b. Signature and title of certifier	3C	M	D. 29c. Licer	7405	29	9d. Date signed (Monto) $2/25/6$	th, Day, Year)
	3		30. Name and address of person of LIAQAT	who completed cause of de		(Type. Print)	Baltimo	ums) 2/20/	
şi i	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 8		r's Signature	Sparke				

			1 - For State Registrar	State of Maryland		artment of F <i>tificate of</i>		Mental Hy	ygiene Reg. No. 006	05922
	Physici	an	Decedent's Name (First, Middle, Last)				Veiss	2. Date of D Month	Day Yea	
1	/Medic	al	E//en 4a. Facility Name (If not institution, give	street and number			r Location of Deat	Februa	4c. County of D	
	Examir	ier	The Johns Ho	okins Hosp	oital	Balt	more	City	4c. County of D	N/A
	Funeral Director		5. Social Security Number 6. Set 1	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		orth 9.1 Pay, 1946	Birthplace (State or Foreign Country)
	pg k		Usual Residence of Decedent 10a. State 10b. County	10c Cib	, Town or Lo	cation				10d. Inside City Limits
	Maryis febo	ō	MD BALTIMO			STERSTOWN	1			1 ☐ Yes 2 No
	n 18a	irec	10e. Street and Number			10f. Zip Code	<u> </u>		10g. Citizen of What	Country?
	23a c	alD	11962 LONG LAKE	DRIVE			21136	5		USA
926	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hyglene. Importants if item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ODGe.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cub I□ Yes 2[X] No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. WHITE
5-0	72 ho natur	eted	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occup	during most of wo	rking	16b. Kind of Busine	ss/industry
21215-0036	within ene. then	Completed	Elementary/Secondary (0-12) 5-	College (1-4or 5+)		DO <i>NOT u</i> se retire: CHER	d) "		EDUCATIO	N
<u>م</u>	e filed at Hygi other vent,	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	e, Maiden Surname)	
<u> yaa</u>	Ments Ments Marked	To	PHILIP		KNI		DOROT			NEEDLE
Maryland	id 2 sh Ith and Ith and 27 ie m traum		19a. Informant's Name/Relationship (Ty BARRY WEISS / HU						ber, City or Town, State STERSTOWN ,	
	s 1 and Heel		20a. Method of Disposition	20b. Pi	ace of Dispo	sition (Name of natory or other place	T	Date	20c. Location - City	
Ē	Page ment c ant: if ury or		1 X Burial 2 □ Cremation 3 □ P 4 □ Donation 5 □ Other (Specify)	emoval from State		NTEFIORE		26/2006	HALET	HORPE, MD
Baltimore,	permit. Depertimport any inj once.		21. Signature of Funeral Service License	adden	1	Name and Address Name Address N			NSON & BRO	
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death ne cause on each line.	. Do not ente	er the mode of dyir	g, such as cardia	c or respiratory	arrest,	Approximate Interval Between Onset and Death
).	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Pulmonar	y 14	ypersensi	0-7			9 40415
	Examiner			Due to (or as a consequ		h v				7 years
1	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ						
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	4	ibrosis				31 years
58760,	icate be executed physiclen and s the burial-transit	edical E		1	101100 017.					
	artificating physes as the	Medi	IF FEMALE:							
P.O. Box	Attending Physician: The law requires that the death certificate be executed robath. croes. croes this certificate has been signed by the attending physicien and y the funeral director, page 2 should be detached for use as the burial-transit	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ď.	ss that gned b	by Pr	Part II. Other significant conditions cor	tributing to death but not resu	Ilting in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco use contribute	to the cause of death?
ord G	w require been sig should b	ted						1 🗆	Yes 2. Mar No 3 □	Probably 4 Unknown
Division of Vital Records,	The law of the law of the has by page 2 st	Completed						24a. Wa auto peri 1 ☐ Yes	opsy prior formed? death	autopsy findings available to completion of cause of ? Yes 2 No
Zita Zita	iclan; certific rector,	Be	25. Was case referred to medical examiner?	lospital:		t 3D DOA Oth	05	ath (Check only		
ō	g Phys er this eral di	n; To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	28b. Time of	· ob box	- Italiania i		idence 6 Other (S how injury occurred	pecify)
ion	ath. rath. or: Afte	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □ No			
Divis	al or Atte s after de il Directo id in by ti	Sertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office			(Street and Number or own, State)	Rural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a Certifier 1 X Certifying Physical (Check only one) 2 Medical Examin	eician: To the best of my knowner: On the basis of examinat and manner stated.	Madge, death ion and/or inv	restigation, in my o	ne, data and place pinion, death occi	s, and due to the urred at the time	date and place, and c	થા સંથાની. due to the cause(s)
	To th To th COMP	W	29b. Signature and title of certifier	6.0 m.a		29c. Licens	e number		29d. Date signed (Mo	•
	3		Synette Brown P.			Res-	٥٥٥		February .	24,2006
	10		30. Name and address of person who co	Hopkins Hospit	1. 40	O North	wolfe.	Ballimore	, Maryla.	el 21287
į.	Sta Registr	te	31. Date filed (Month, Day, Year) FEB 2 8 200	38. Registrar's Signat	рге Дов					

			1 - State Registrar	State of Ma	aryland .	-	artmen rtificat			and M		giene	05923	
	Physici		1. Decedent's Name (First, Middle,	Last)	VS					Ì	2. Date of Dea Month	Day	3. Time of Death	м
	/Medic Examir		4a. Facility Name (If not institution,	give street and number)	VC		4b. City.	Town, or	Location of	of Death	(40)	4c. County of	f Death	
	Funeral Director	lei	5. Social Security Number 220-07-1212	retainle	Wachu e (In yrs. last	birthday) Yrs.	on to a series of the series o	(Winder Hours	Bu	8. Date of Birti (Month, Day 9-22-	Anne	9. Birthplace (State or Foreig Country)	gn
	pua *		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits	-
	/aryt	5		A 1 . 1	,								1 ☐ Yes 2 ☒ No	
	28a-	ect	MD Anne 10e. Street and Number	Arundel	Gler	ı Bur	nie 10f. Zip	Codo				10g. Citizen of Wh		
	with with	ā		1										
	eath	era	304 Baylor Road	12. Was Decedent I	Ever in 11 S	13.1		1061		ain? (Sne	ocify Ves or No.	U.S.A	- American Indian,	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2∑XMarrie 3 ☐ Widowed 4 ☐ Divorced	Amed Forces?			If Yes, spec		Specify:	, Puerto	acify Yes or No- Rican, etc.)	Black,	White	
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Уa	2 should be fi and Mental H is marked of sumatic ever	2	George Zivec						Ant	onio	Pazaka	as		
lar	C a ≈ g	6 1	19a. Informant's Name/Relationsh		11.		-					r, City or Town, Si		
	1 and Health Sem 27 sther tr		Mr. Earl Hurley	/ nephew								sville, M		
Baltimore,	of Heal		20a. Method of Disposition 1 XBurial 2 Cremation	3 ∏Removal from State	20b. Place ceme	e of Dispo etery, crer	sition (Nam natory or o	ne of ther place	9)		ate	20c. Location - C	ity or Town, State	
E	Pages ment of I ant: If ite		4 ☐ Donation 5 ☐ Other (Sp		Loud	lon P	ark C	emet	ery	3-2-	-2006	Baltimor	e, MD	
alt	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeral Service L	censee	/	22	. Name an	d Addres	s of Facilit	y Si	ngletor	n Funeral	L Home, PA	
ш_	205 20	1 15	Mark al	· Manura	Mo13	57	1 Se	cond	Ave	SW;	Glen Bu	rnie, MI	21061	
3	Physician		23a. Part1. Efter the disease, or o shock, or heart failure. List o immediate Cause (Final disease or condition resulting in death)	nty one cause on each lir	the death. Ine.				A #			rest,	Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ce of):	Mo	IMA	vol	001				
	*	_	Sequentially list conditions,	b		J (-	47				
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	Ce OI):								
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8760,	ate be executed hysician and the burial-transit			Due to (or as	a consequen	CB OI).								
87	physi	dicai	3.5	d										
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Records, P.	quires that n signed by	þ	Part II. Other significant condition	s contributing to death bu	ut not resultin	ig in the ui	nderlying c	ause give	n in Part I.		İ		oute to the cause of death?	'n
00	w requir s been si should	Completed									24a. Was a	an 24b. We	ere autopsy findings available	le
Re	The lav	E									autop perfor	sy prid med de	or to completion of cause of ath?	٢,
Vital		0	25. Was case referred to medical			-750	-		26 Place	of Death	1 ☐ Yes		⊒Yes 2≝No	
>	Physician: this certificanal director.	0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	nt 2□EB/	/Outpatien	it 3 DC	Othe	er.			ence 6 Other	(Specific)	-
o		Ė	27. Mannar of Death	28a. Date of Injur	y 281	b. Time of		8c. Injury Work				ow injury occurred		
io	Attending I ir death. ector: After by the funer	at o	1 Natural 5 Pending 2 Accident investiga	(Month, Day	/ rear)	Injury	м		? ′es 2 🔲 l	No				
Division	in Pite	Certification:	3 Suicide 6 Could no determine		ury - At home, c. (Specify)	, farm, str	eet, factory	, office			28f. Location (S City or Tow		or Rural Route Number,	
_	Hospital		29a. Certifier 1 Certifying	Physician: To the best of	of my knowled	dan dant		at the tim	o data an	dalaaa	and due to the o			
	24 h 24 h Fun etely	Medicai	(Check only 2 Medical E	xaminer: On the basis of and manner sta	examination	and/or inv	vestigation,	in my op	inion, deal	th occurr	and due to the o	ause(s) and manr late and place, an	d due to the cause(s)	
	To the within To the compli	Me	29b. Signature and title of certifier				29c	. License	number		- 2	29d. Date signed ((Month, Day, Year)	_
	6484		1 Lames	Jun Will	L W	MD.		D4	1365	_			26, 2006	
	0		30 Name and address of parece ::	to completed cause of d	eath (Item 22	la) (Tucc	Print\				7	LA		
	7		30. Name and address of person w	ides I MD	301			Dr	rie,	Gle	m Bur	nie, MD	. 21061	
	Sta Registr	-		006 22. Hegistra	ar's Signature									

			For State Registrar	State of Ma	*	epartme Certifica				iene 0 0	6	05924
	Physicia		1. Decedent's Name (First, Middle, Las IRENE	OLIVIA			ABA	ח	2. Date of Death Month	Day	Year	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give Pent HUIA REGIONAL		Contar		y, Town, or	Location of Death	1	4c. County of		n c2
^	Funeral Director	- 1	772-16-2330	9x 7. Age □ M 2X F	e (In yrs. last birth	day) If Und Month	er 1 Year S Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 31,	1921	Cour	place (State or Foreign htry) BW BTE
-4330	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Wicomic	00	10c. City, Town	or Location					1	0d. Inside City Limits 1 K Yes 2 No
6	with the	Director	10e. Street and Number 13 West Chestnut				ip Code	875	10	g. Citizen of W	hat Cour USA	ntry?
J 722-16	'2 hours after deeth with the Maryland tatural', or items 23a or 28s-1 show Isal Examinan must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nover Married 2 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 Å N If Yes, Give Year or Dates:			edent of Hi ecify Cuba	ispanic Origin? (Sp. Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race	- Americ , White,	
L Aba d 21215	filed within 72 Hygiene. other ther: "na ent, the Medic	Be Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 11th 17. Father's Name (First, Middle, Last)		+)	life. DO NOT	vork doné d use retired	during most of world) Technici	king		univ	
Marylan	should be and Mental amarked o	ToB	Paul 19a. Informant's Name/Relationship (7)	Con Print		n, Sr.	/244	Edith	ral Route Number,		Haye	
	es 1 and 2 should b of Health and Ment of Hem 27 is marked r other traumatic	-	Nancy Braham/ dau	• • • • • • • • • • • • • • • • • • • •	100	0 Pine	Stree		nar, Mary	land 21	875	
Baltimore,	Peges 1 nent of H int: If ite		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. Place of E cemetery, Salisbury	crematory of	other plac			20c. Location - 0 alisbury	•	
Balti	permit. Peg Department Important: I eny injury o		21. Signature on Funeral Service Licen	5. Jall	24	JOLLE	Y ME	EMORIAL	CHAPEL		- Sal	lisbury, MD 21801
	Physician /Medical Examiner	ner	23a. Part1. Ever the disease, or compshock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. CH Due to (or as a control of the	a consequence of PD a consequence of):			or respiratory arre	est,		Approximate Interval Between Onset and Death
68760, <	ate be thysicie	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):		1705)			
Вох	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ► ♥ 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic 5 □ Other (23d. Date Mon		ery Day Year
ords, F	w requires that been signed I should be det	ted by P	Part II. Other significant conditions co	ontributing to death bu	ut not resulting in t	he underlying	cause give	en in Part I.				ne cause of death?
al Reco	ictan: The law r certificate hes be rector, page 2 sh	Completed							24a. Was ar autopsy perform 1 Yes 2	ned? de	ere auto rior to cor eath?	psy findings available mpletion of cause of 2 No
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 10 10 10 10 10 10 10 10 10	Hospital: 1 Inpaties 28a. Date of Injur (Month, Day		ne of	28c. Injury Work	er: 4 ☐ Nursing He	th (Check only one ome 5 Reside 28d. Describe ho	nce 6 Othe		·у)
Divis	tal or Attending rs after death. el Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury - At home, farm c. (Specify)	n, street, facto	ory, office		28f. Location (Str City or Town		r or Rura	al Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	Medical	one)	ysician: To the best of iner: On the basis of and manner sta	of my knowledge, of examination and/lited.	death occurre or investigation	d at the timen, in my op	ne, date and place, pinion, death occur	, and due to the ca rred at the time, da	use(s) and man ite and place, a	ner as st	tated. the cause(s)
			29b. Signature and title of certifier	· D .	·	2	D 5	7952	Lisbury	2/15	/ 2	Day, Year)
	3		30. Name and address of person who of Babilal Dan	completed cause of de	eath (Item 23a) (To	ype, Print)	# 5	043 5	Lisbury	141) 2	180)
4	Stat Registra		31. Date filed (Month, Day, Year) FEB 2 8	32. Registra	ar's Signature	fores	4					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month RUTH ANDERS FEBRUARY 10 2006 4:53P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, May 28) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2**X**☐ F 91 Maryland 213-16-1892 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at Maryland | Frederick 1 √ Yes 2 No Director Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 59 East Moser Road 21788 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: 3 Widowed 4 □ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than any Injury or other traumatic avant Elementary/Secondary (0-12) Coilege (1-4or 5+) Seamstress Claire Frock 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Emory Layton Moser Catherine E. Shellenberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Beard / Daughter 101 Catoctin Avenue Apt. #1, Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Speorly) Resthaven Mem. Gardens 2/14/06 Frederick, Maryland 21. Signature of Funeral Servic License ROBERT E. DATLEY & SON FUNERAL HOMES, 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part1. Enter the disease, or compleations that caused the shock, or heart failure. List only one cause on each line s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit and attending physician for use as the buria Box 68760. Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 moorns? 23d Date of delivery 3 Ectopic pregnancy Month Dav Year 4 □ Pregnant at time of death 5 Other (specify) ed by the a Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has 2 No 1 Yes 1 ☐ Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director; A completely filled in by the fi 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Dale signed (Month, Day, Year) 29b. Signature and title D0029591 23a) (Type, Print) Tohnson Dr. FREDERICK, MD 21702 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day FEBRUARY 8, 2006 **Physician** 2:05 AMELEANOR C. ARMSTRONG /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F Yrs. WASHINGTON, DC Director 578-18-1228 87 10/14/1918 Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f ehow The Medical Examiner must be notified at 1 ☐ Yes 2 🖾 No Director MARYLAND MONTGOMERY SILVER SPRING 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20904 3114 KILKENNY STREET 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 Å No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. e filed within 72 hours after al Hygiene.
I other than "natural", or Ita 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: þ WHITE 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE AGENT REAL ESTATE other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked oth any injury or other traumatic event one. Be 2 **GEORGE** CORBIN ELTON WEAVER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3114 KILKENNY STREET, SILVER SPRING, MARYLAND 20904 WILLIAM J. ARMSTRONG III/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) UNION CEMETERY 02/13/2006 BURTONSVILLE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erres Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 8 cete hes been signated bage 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ŽiUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 \bigsi No 1 Yes 2□ No 1 ☐ Yes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical 26. Place of Death | Check only one examiner' Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1 🖾 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check or one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) certif FEBRUARY 8, 2006 D0062885 30. Name and address of tho completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

person

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2006

SONJA WYCHE, 31. Date filed (Month, Day, Year)

FEB

1500 FOREST GLEN ROAD, SILVER SPRING, MARYLAND 20910

32. Registrar's Signature

Registra

8 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 16a b 18 per ft 9852 2-28-06 vt
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10,2006 FEBRUARY 3:10A M SHIRLEY DIANE BLAIR 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CHARLES COUNTY NURSING & REHAB. LA PLATA CHARLES | H Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Fo. Country) | SEPT.18,1941 | WASH., D.C. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 🗓 F 213-40-9410 64 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1XX es 2 ☐ No MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 10200 LA PLATA ROAD 20646 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes XXNo Specify: 3 Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) . 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper McCrea Equipment 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HAROLD DAVID ROWE VIRGINIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KEVIN BOWEN-SON IN LAW 8940 BRIDGETT LANE, LA PLATA, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) CEDAR HILL CEMETERY 2-15-06 SUITLAND, MARYLAND 22 Name and Address of Facility 21. Signature of Furtieral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A. 1-cc PLATA, MARYLAND 20646 rthe mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that daused the death. Do not shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) euphel Vascula oberse Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

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rthen *netural', or Items 23s or 28e-f ehow Ite Medical Exa⊤irer must be notified at

Maryland 21215-0036

Baltimore,

68760,

P.O.

Division of Vital Records,

Hospitel or Attending

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permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then eny injury or other traumett.

Examiner physicien and the burial-transit Physician/Medical attending ph for use as the ed by the a ģ cete has been si Completed certificete the funeral director, this After I Certification; death. within 24 hours after death To the Funeral Director:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 26. Place of Death | Check only one examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Solo 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

15016000

29d. Date signed (Month, Day, Year)

2/10/06

3

Registrar

filled in by

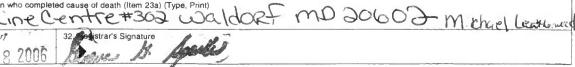
31. Date filed (Month, Day, Tear) State

29b. Signature and title of certifier

13010 OR1

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

Medical

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פ פ	a th	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, N				
Maryland	ked cev	ToB	Leonard Paul Be	11, Sr.			Doris	A. 1	3ade			
7	D W	-	19a. Informant's Name/Relationship	Type, Print)	19b. Maili	na Address (Street	and Number or Run	al Route Number.	City or Town.	State. Zio (Code)	
20 5	tre.	i I	Doris A. Gregory,			-	nue, Fair				,	
o :	Head Head		20a. Method of Disposition		b. Place of Dispo	sition (Name of	! !		Oc. Location		vn. State	
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4	within 24 hours effer death. To the Funeral Director: After this certificate his completely filled in by the funeral director, pege	Medical	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signe	d (Month: I)	av, Yearl	
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			30. Name and address of person who Zabiullah Ali, M.		(Item 23a) (Type, 1111 Pen:	Print) n Street	Baltimor	e. Marv1	and 21	201		
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	/Medi		Virginia K.	Baka1							ebruai		.006	10:00 A M
	Examir	ier,	4a. Facility Name (If not institution, giv	e street and number,)		4b. City, To					1	ty of Deatr	
			102 Winnie Place 5. Social Security Number 6. S	ex 7 A	ge (In yrs. la	st birthday)	Ga1		sbur		Date of Bird		t gome	
	Funeral Director			□M 2[X]F	83	Yrs.	Months [ays	Hours	Min.	B. Date of Bird (Month, Da Aug. 28	y, Year)	CA	iplace (State or Foreign intry)
	D		Usual Residence of Decedent									,		
	arylar	٠.	10a. State 10b. County		10c. City,	, Town or Lo								10d. Inside City Limits 1 XYes 2 ☐ No
	8a-f	ecto	MD Montgome	ery		Gait	nersbu							
	a or 2	Funeral Director	10e. Street and Number 102 Winnie Place				10f. Zip Co	ode	2087	7		10g. Citizen o		1
	ne 23	era	11. Marital Status	12. Was Decedent	Ever in U.S	3. 13.	Was Deceder	t of His	panic Orio	gin? (Speci	ify Yes or No			ican Indian,
36	n 72 hours after death with the Maryland "netural", or Iteme 23s or 28s-f show adical Examiner must be notified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Divorced	Armed Forces' 1 ☐ Yes 2 [X] If Yes, Give	?		Was Deceder f Yes, specify 1 ☐ Yes 2 🖸	_	, Mexican Specify:	i, Puèrto Ri	can, etc.)	Spec	ack, White	e, etc.
8	hour tural	ed b	15. Decedent's E	Year or Dates:	1	16a Dece	dent's Usual (Occupat	ion			16b. Kind of		nite
15	c _ @	Completed	(Specify only highest gra	de completed)	5.)	(Give	kind of work	done du	iring most	t of working	7	TOD. KING OF	DU3111653/11	noustry
212	d within piene. r then	luo l	Elementary/Secondary (0-12)	College (1-4or	5+)	E1e	ctrica	1 E1	ngine	eer		Engi	ineer	ing
שַ	e filed v Il Hygie other I vent, th	Be C	17. Father's Name (First, Middle, Last,)							First, Middle,	Maiden Suma		
/lar	should be and Mental I	ToE	Mervin Dye						Silv	⁄ia ₹	Jnavai	lab1e		
Baltimore, Maryland 21215-0036	and and ls m		19a. Informant's Name/Relationship (Byron Bakalis/So	* * *								er, City or Tow urg, MI		
آ	1 and Health Iem 27 other tr		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name	of	-	Dai		20c. Location		
БĽ	Pages nent of int: if it		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Met	ropol	natory or other	r place)) E	ebrua	ary 13	A 1 o x a	ndada	a, Virginia
aH:	그 두 쪽 글		21. Signature of Funeral Service Licer			Crema 22	Name and	Address						, 10 East
Ä	Departiment Departiment Departiment Departiment Departiment Department Depart		TRACYA. STU	VER		D	eer Pa	rk I	Drive	, Gai	ithers	burg, M	\mathbb{D} 208	377
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each i	d the death.	. Do not ent	er the mode o	of dying,	such as	cardiac or i	respiratory ar	rrest,		Approximate Interval Between
	Pnysician	0.7	Immediate Cause (Final disease or condition	a. Arry	thmia	ı								Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as										
	3.00	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as			arctio	n					-	
	uted d ansit	Examlner	Sequentially list conditions, if any, leading to immediate cause. The uncoming Cause (Disease or injury that initiated events	•										
oʻ	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as	a consequ	ence of):								
8760,	death certiticate be executed e attending physician and ct or use as the burial-transit	dlcal		d										
9	n certitics anding pl use as t	Med	IF FEMALE:											
Вох	eath co attend tor us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3	Ectopic preg						ate of delive Month	/ery Day Year
0	at the de by the a tached 1	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	it time of de	atn 5L	Other (spec	Ty)						
a	that the seed by detail		Part II. Other significant conditions of	contributing to death I	but not resul	lting in the u	nderlying cau	se giver	n in Part I.		23e. Did to	obacco use co	ntribute to	the cause of death?
of Vital Records,	The taw requires that the te has been signed by the bage 2 should be detache	ed by	Osteoporosis								101	∕es 2. XNo	3 🗌 Pro	bably 4 Unknown
000	law requir as been si 2 should l	plete	Chronic Congest	ive Heart	Failu	re					24a. Was			opsy findings available
R	The tate has page	Completed									autor perfo 1 Yes	rmed? 2 X No	death?	ompletion of cause of a 2 No
ita	icien: T sertiticat ector, pa	Be C	25. Was case referred to medical examiner?						26. Place	of Death /	Check only o			
<u>></u>	dir dir	2	1 ☐ Yes 2 💢 No			ER/Outpatien	t 3□ DOA	Other	4 🔲 190	rsing Home	5 XResid	dence 6 🗆 O	ther (Spec	ify)
		on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury		Mork?	?		d. Describe I	now injury occu	ırred	
Sio	tor: the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Α	ive. At hos	na farm at	M		es 2□ľ		f Location /	Stroot and Nur	nhor or Pu	ral Route Number,
Division	atter death Director:	ertification;	4 Homicide determined	28e. Place of In building, e	tc. (Specify)) arm, str	eet, ractory, o	IIICO		20	City or Tov		יטפו טו הטו	ar moute Mulliper,
	To the Hospitel or At within 24 hours after of To the Funerel Directompletely filled in by	O	29a. Certifier 1 X Certifying Ph	ysician: To the best	of my know	vledge, death	occurred at	the time	, date and	d place, an	d due to the	cause(s) and n	nanner as	stated.
	the Ho	ledical	one)	niner: On the basis of and manner si	of examination	on and/or in				th occurred				
	To the To the complet	Σ	29b. Signature and title of certifier	0.			29c. L	icense	number			29d. Date sign	ied (Month	, Day, Year)
,	7		1 1					76	569	1		2.8	06	
			30. Name and address of person who Dr. Raman Tuli, N	***				#2∩	2. C	aitho	rehura	r MTD O	N 2 7 0	
	Sta	te.	31. Date filed (Month, Day, Year)		rar's Signati		vii Ku,	# 2 0	2, 6	arthe	repurg	5, MD 20	V0/8_	
	Registi		FEB 10	2006	gas d	Jo phy								

State of Maryland / Department of Health and Mental Hygiene, 1- State Registrar Amended #23a & #26 per MD FCHArtificate of DeathKS 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Virginia Czeszynski February 6, 2006 7:03 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖼 Months Director 397-18-5289 80 Yrs February 20,1925 Wisconsin Usual Residence of Decedent the Maryland 10b. Count 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Itema 23a or 28a-f ehow other traumatic event, the Mudical Examinar must be notified at Maryland Frederick Brunswick 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 604 Brunswick Street 21716 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ 3 ₩Widowed 4 Divorced Specify: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry be filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fill and Mental H William Fecteau Clara Gilbeau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an Denise Hooper - Daughter 604 Brunswick Street, Brunswick, Maryland 21716 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot olace) 1 Burial 2 Cremation 3 Removal from State Frederick Crematory 2/8/2006 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Lensee_ Maron line 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Probable **Physician** disease or condition resulting in death) moutes /Medical Due to (or as a consequence of) Examiner sopora. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a detached f 9 Unknown signed by t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Phosidence 6 Other (Specify) 2 R/Outpatient 10 1 ☐ Yes 2 No 1 Inpatient 3□ DOA this After thi funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Watural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Zu Medical Examifrier: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mD00576890 216/2006 37 Name and address of person who completed cause of death (Item 23a) (Type, Print) Oth Lucius Brusswell MD GETOLONO 32. Register's Signature

06 Security Signature 31. Date filed (Month, Day, Yea State 2006 Registrar

Director State	ge (In yrs. last birthday) 79 Yrs. 10c. City, Town or Lo P0I	Por If Under 1 Year Months Days	Hours Min. 2067! Hispanic Origin? (Span, Mexican, Puerto	8. Date of Birth (Month, Qay.) Feb. 4,	pay Year 2006 4c. County of Dea Char 9. Bir C 1927 Was S	Tes thiplace (State or Foreign punity) nington DC 10d. Inside City Limits 1 □ Yes 2 No
4370 Tulip Drive 5. Social Security Number 578-24-4527 Usual Residence of Decedent	ge (In yrs. last birthday) 79 Yrs. 10c. City, Town or Lo P0I	Por If Under 1 Year Months Days Decation Mfret 101. Zip Code Was Decedent of If Yes, specify Cub	If Under 24 Hrs. Hours Min. 20675 Hispanic Origin? (Span, Mexican, Puerto	8. Date of Birth (Month, Qay.) Feb. 4,	Char 1927 9. Bir 1927 Wass	Tes Implace (State or Foreign Introduction DC 10d. Inside City Limits 1 Yes 2 No
Director 578-24-4527 1 M 2 F Usual Residence of Decedent	79 Yrs. 10c. City, Town or Lo Pol REver in U.S. Pol 1944-47	mfret 10f. Zip Code Was Decedent of If If Yes, specify Cub	Hours Min. 2067! Hispanic Origin? (Span, Mexican, Puerto	5	g. Citizen of What Co	10d. Inside City Limits 1 □ Yes 2 ☑ No
	Pol t Ever in U.S. 13. Y No 1944-47	mfret 10f. Zip Code Was Decedent of Hif Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	5	USA	1 ☐ Yes 2 🛣 No
4370 Tulip Drive	1944-47		Hispanic Origin? (Sp an, Mexican, Puerto	5	USA	ŕ
9 E 1	1944-47	1 ☐ Yes 2 ∤ ☐ No			Black, White	erican Indian, le, etc.
The state of the s	life. I	dent's Usual Occup kind of work done DO NOT use retire		ing 10	Specify: W	hite //ndustry
The state of the s	5+1	reman	18. Mother's Name			partment
19a. Informant's Name/Relationship (Type, Print) Patrick Capps - Son			and Number or Rur	al Route Number, (City or Town, State, .	
20a. Method of Disposition 1	Maryland	Veterans	s Cem 2-16	5-06 Ch	eltenham,	MD
23a. Part1. Enter the disease, or complications that caused	Hu		eral Home	POB 156		, MD 20604 Approximate
Physician Immediate Cause (Final disease or condition resulting in death)	ine. C c s a consequence of):	_				Interval Between Onset and Death
	a consequence of):					
The state of the s	2 Fetal death 3	Ectopic pregnancy	y		23d. Date of del Month	ivery Day Year
Part II. Other significant conditions contributing to death b	out not resulting in the ur	nderlying cause giv	ven in Part I.		cco use contribute to	the cause of death?
The date page					prior to death?	itopsy findings available completion of cause of 2 No
25. Was case referred to medical examiner? 1	ury 28b. Time of	28c. Injur Wor	er: 4 □ Nursing Houy at k?	me S Resident	ce 6 Other (Specialized	city)
3 Suicide 6 Could not be determined building, et	jury - At home, farm, stre lc. <i>(Specify)</i>	eet, factory, office		City or Town,		
29a. Certifier Check only one) 20m Medical Examiner: On the basis of and manner state.	or examination and/or inv	estigation, in my o	pinion, death occurr	ed at the time, date	e and place, and due	to the cause(s)
Horse Myo	togeth (Norm 22a) (Time	29c. Licens	A L	290	Date signed (Month	o, Day, Year)
30. Name and address of person who completed cause of d Dr. Krishan Mathur, 3500 0 State Registrar 31. Date filed (Month, Day, Year) FEB 1 3 2006	ld Washingt	ton Road,	Suite 10	2, Waldo	rf, MD 206	502

			1 - For State	State of Mary		artment of H rtificate of L		Mental Hy			
			Registrar 1. Decedent's Name (First, Middle, Las	*)	06	uncate of L	Jeani	2. Date of De	Reg. No.		3. Time of Death
	Physici	an	. Seconditio Hamo (First, Imagic, Eas	,			11	Month	Day	Year	3. Time of Death
	/Medic		JOSIA	-	9 MES	CALLO	WAY		RY 14		1014
	Examin	ier	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea	ath	4c. Coun	ity of Death	
			CHESTER RIVER	2 HOSPITA	CENTE	R CA	-IESTER			ENT	
	Funeral		5. Social Security Number 6. Se	M 2□F	n yrs. last birthday) On Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th iy, Year)	Coun	
	Director	ļ	217-30-8498 Usual Residence of Decedent		80 Yrs.			12/5/	1925	M	D
	land		10a. State 10b. County	10	c. City, Town or Lo	cation				1	0d. Inside City Limits
	Mary fah	ō	MD Queen A	nne's	Church	Hill					1 ☐ Yes X ☐ No
	the 288	ec	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Coun	stn/2
	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-1 ahow the Madical Examinating the molified at	Funeral Director	1011 Sudlersvil	le Road		21623			USA	Wilat Court	nty:
	ns 23	era	11. Marital Status	12. Was Decedent Ever	rin U.S. 13	Was Decedent of Hi	spanic Origin? (Specify Ves or No		ace - Americ	an Indian
	ter o	Ë	1 □ Never Married 🌠 Married	Armed Forces? 1 ☐ Yes 2 💥 No		f Yes, specify Cuba	n, Mexican, Pue	rto Rican, etc.)		lack, White,	
38	ursal	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Spec	ify: Whi	te
ŏ	2 hou	Completed	15. Decedent's Edi		16a, Dece	dent's Usual Occupa	ation		16b. Kind of	Business/Inc	fuetny
7.	in 72 n "n n "n	plet	(Specify only highest grad	le completed)	(Give	kind of work done a DO NOT use retired,	turing most of w	orking	100.11.11.0	20011100041110	Justiy
21215-0036	with iene r tha	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Farm	er			Agric	cultu	re
	filed Hyg othar		17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other then "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinations that be notified at once.	To Be	James T. Callow	ay .			Sara	h Myrth	Wadde	ell	
7	Shound M mar mat	-	19a, Informant's Name/Relationship (T	ype, Print)	19b. Mailir	ng Address (Street a	and Number or F	Rural Route Numb	ar. City or Tow	n State Zin	Code)
Š	od 2 Ith an 27 is		Edith Calloway	Wife							MD 21623
ō,	1 ar Hea tam 3		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	1	Date	20c. Location		
<u>ō</u>	ages nt of r. Hij		1 🔀 Burial 2 □ Cremation 3 □ I		_	natory or other place		17/06		,	A
altimore,	rtme rtani ritani		' 4 ☐ Donation 5 ☐ Other (Specify,			Hill Ce		17/06	Church	ı HII	I, MD
Ba	Deporting any in		21. Signature of Funeral Service Licens	,		. Name and Addres		nbein &	Newna	am Fu	neral Hor
			your tello			70 W. C	voress	_St. Mi	llingt	on,	MD 21651
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each line.	death. Do not ent	er the mode of dying	g, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between
Ч	Pnysician		Immediate Cause (Final disease or condition	Duly	ionan	1. Ered	Men	n			Onset and Death
	/Medical		resulting in death)	ue to (or as a co	onsequence of):					2	- and
	Examiner		Sequentially list conditions,	ash	ration	Preur	2 mars			6	- day
	D =	ner	if any, leading to immediate	Due to (or as a co	onsequence of):						P
	cute	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c							Ø
ó	an an an an an an an an		resulting in death) Last	Due to (or as a co	nsequence of):						
68760	ficate be executed physician and is the burial-transit	edical		d							
		led							1		
Вох	leath certiff attending I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		To a series of the series of t			23d. D	ate of delive	ry
	deat e atte id for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		Ectopic pregnancy Other (specify)			N	fonth	Day Year
0.0	t the by th ache	hys	9 Unknown	9□ Unknown							
	The law requires that the death certi Ite has been signed by the attending page 2 should be detached for use a	by P	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the ur	nderlying cause give	n in Part I.	23e. Did to	obacco use co	ntribute to the	e cause of death?
Vital Records,	quire n sig ald b	D	OCOPD 2	Genera S	mal	Sixeno	240	. 101	res 2 No	3 ☐ Proba	ably 4 DUnknown
00	w rec	Completed	a Hallong to	Paris To	me Pen		ect	24a. Was	an 24h	Woro auton	sy findings available
Re	ne lav	E C	317034199	Carring	mejen	caroun	7 3	autop		prior to com death?	pletion of cause of
a	ician: Th certificate rector, pag							1 □ Yes	2 No	1 ☐ Yes	2 🗋 No
Ĭ	certi	o Be	25. Was case referred to medical examiner?	Hospital:		Othe		ath (Check only o			
ot	Phys this al dii	\vdash	1 ☐ Yes 2 ☐ No 27. Mann f Death	1 Empatient	2 ER/Outpatien	t 3 DOA	* 4 □ Nursing	Home 5 ☐ Resid)
Division of	ding l	Certification;	1 Autural 5 Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	28c. Injury Work		28d. Describe h	low injury occu	irred	
S	uttandi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be				′es 2 □ No				
\leq	f or Attandater deatl	Ħ	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre pecify)	et, factory, office		28f. Location (S City or Tox		nber or Rurai	Route Number,
	To the Hospital or Attanding Physician: The within 24 hours after death. To tha Funaral Director: After this certificate his completely filled in by the funeral director, page		20 0 11 1	<u> </u>							
	Hosi 14 ho Funs ely fi	edical	(Check only 2 Medical Exami	sician: To the best of my ner: On the basis of exa	y knowledge, death ımination and/or inv	occurred at the time restigation, in my on	e, date and placinion, death occ	e, and due to the urred at the time	cause(s) and m	nanner as sta	ated. the cause(s)
	the hin 2 tha nplet	Med	01107	and manner stated.							
	To To	~	29b. Signature and title of certifier	1 - 1		29c. License			29d. Date sign	ed (Month, E	ay, Year)
1	0		16 Callun	-, IVID.			1313		2/14	406	
	8)5		30. Name and address of person who co		1 1- 2	Print)	01-	ledour	ma	-11	
_			KINKWUN	7	001-	n Ave.	, cuis	edour	(Jul)	262	0
	Sta	1 1	31. Date filed (Month, Day Year) FEB 1 7	32. Registar's \$	Signature /	0					
	Registra	1	· 1	LUUU PARKA	47	All NO					

			1 - For State Registrar	State of Marylar		artmen rtificate			ind M	, ,	iene	nna	059	34
			1. Decedent's Name (First, Middle, Last)							2. Date of Deat Month			3. Time o	of Death
	Physici /Medio		JAMES E.	COOPER,	Sr							2006	2:44	A M
	Examir		4a. Facility Name (If not institution, give s			4b. City,	Town, or	Location of	f Death		4c.	County of D	eath	
			Suburban Hos	4			the		34 11				GOMERY	
	Funeral Director		5. Social Security Number 6. Sex 578-40-1396	7. Age (In yrs. 80	Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Sept. 6	Year)	9.	Birthplace (State Country)	or Foreign ∽ ⊿
			Usual Residence of Decedent							pept.	3 , <u>T</u>	923	Maryla	IIG
	yland		10a. State 10b. County		ty, Town or Lo								10d. Inside C	City Limits
	e Ma	cto	MD Montgo	mery	E	otom	lac						1 XYes	2 🗆 No
	or 28	Director	10e. Street and Number			10f. Zip				1	0g. Citi:	zen of What		
	ath w		7749 Scotlan				208					U.S.		
	within 72 hours after death with the Maryland ene. Than "natural", or itema 28e or 28e-f ahow na Madical Examiner must be notified a	Funeral	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Deced If Yes, spec	lent of History offy Cubar	spanic Orig n, Mexican,	in? (Spe , Puerto I	cify Yes or No- Rican, etc.)			merican Indian, hite, etc.	
39	urs af		3 ∰Widowed 4 □ Divorced	1 √Yes 2 □ No If Yes, Give Year or Dates: 4 3	3-46	1□Yes 2	2 <mark>X</mark> No	Specify:				Specify:	Black	
215-0036	2 hou	Completed by	15. Decedent's Educ			dent's Usua					16b. Kir	nd of Busine	ss/industry	
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ב		0	17. Father's Name (First, Middle, Last)							(First, Middle, I		,		
Ž	hould d Mei mark matic	ို	James P. Do		10h Mailie	an Addrass	(Ctroot o			hy Mai				
Maryland 2	id 2 si Ith an 27 ia r traur		Roxanne Cooper	•						Potor				
ā,	Heal Heal tem	27	20a. Method of Disposition	20b. F	Place of Dispo	sition (Nan	ne of			The second second second		•	or Town, State	
9 E	ant of the same		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		emetery, crer ate of				2/]	13/06	Si	lver	Spring	, MD
Baltimore,	permit. Pages 1 and 2 should be Deperturent of Health and Menia Important: If Itam 27 is marked any Inlury octibar traumatic at once.	1	21. Jignat per of Funeral Service icens	11						•			HCME .	•
ñ	80 E 8		GNAEL S	nowdeu	14.2	246 N	. W	ash.	St.	, Roc	(Vi	lle,	MD 208	50
п			23a. Part1. Enter the disease, or complice shock, or hear failure. List only on	cations that caused the deat e cause on each line.	h. Do not ent	er the mode	e of dying	g, such as o	cardiac o	r respiratory arre	est,		Approxima Interval Be	tween
	Pnysician	8 4	tmmediate Cause (Final disease or condition	Ischemi	c Bow	<i>i</i> el							Onset and	Death
	/Medical Examiner	Ш	resulting in death)	Due to (or as a consec										
		2	Sequentially list conditions, if any, leading to immediate	. Due to (or as a conseq	mence of):									
	nsit	Examiner	Cause. Enter Underlying Cause (Disease or injury	200 (0) 00 00 00 00	derice or).									
<u>.</u>	exection and iai-tra	Exa	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):									
3/60	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	dicai	d											
9	ntifica of ph as th	Medi	IC CENALE.											
X _O X	eath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pr	egnancy				2	23d. Date of Month	delivery Day	Vaar
	at the dea by the at tached to	Physician/Me	1 Yes 2 No	4☐Pregnant at time of a 9☐Unknown	leath 5	Other (sp	ecify)				Ī	Month	Day	Year
<u>.</u>	that the side by detac		Part II. Other significant conditions conf	tributing to death but not res	ulting in the u	nderlying ca	ause dive	in in Part I		23e. Did tol	рассо и	se contribute	a to the cause of	death?
ds,	uires that signed t id be det	d by	Renal Fai	1						1 □ Ye	s 2[]No 3□	Probably 4X	Unknown
o O	w requir been si should	lete	C+ male a							24a. Was a	n	24h Ware	autopsy findings	available
Vital Record	The lav	Completed	Stroke						_	autops perforr	y ned?	prior	to completion of	cause of
<u>ra</u>	ician: T certifice rector, p	0	25. Was case referred to medical					26. Place	of Death	Check only on		101	′es 2□No	
>	S S	To B	examiner? 1 ☐ Yes 2 📉 No	ospital:	ER/Outpatier	nt 3□ DO	A Othe			ne 5∐Reside		S □Other (S	ipecify)	
n 01	<u> </u>		27. Manner of Death 1 StNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	1 2	8c. Injury Work	at ?		8d. Describe ho				
<u> </u>	tendi Jeath. tor: A the fu	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			М		′es 2□N						
DIVISION	or At after of Diraci in by	Certification;	4 Homicide determined	28e. Place of Injury · At he building, etc. (Specif	ome, farm, str y)	eet, factory	, office		2	8f. Location (St City or Town			Rural Route Nur	n <i>ber</i> ,
	pital ours a neral I		29a. Certifier 1 Certifying Physi	ician: To the best of my kno	wiedne deati	b Occurred	at the tim	e date and	t place a	nd due to the e	21160/c)	and manner	ac stated	
	e Hos	edical		er: On the basis of examina and manner stated.	tion and/or in	vestigation,	in my op	inion, deat	h occurre	d at the time, d	ate and	place, and	due to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Me	29b. Signature and title of certifier			29c	. License	number		2	9d. Date	e signed (M	onth, Day, Year)	
	ie) OK	5. wilks			D0	0631	95		$-\mathbf{F}\epsilon$	eb. 7	, 2006	
	-1		30. Name and address of person who cor	npleted cause of death (Iten	, . ,	,								
			Steven Wilks	, M.D. 860	0 01d	Geo	rget	town	Rā.	, Beth	esc	la, M	D 2081	4
E	Sta Registr		31. Date filed (Month, Day, Year) FEB 10 200	32 Registrar's Signa	imie	sele.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year MALCOLM ALBERT COX Feb 8, 2006 /Medical 11:10a 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Hartley Hall Nursing Home Pocomoke City Worcester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 12/6/1923 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex ★□ M 2□ F Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 82 Director 401-22-7905 Kentucky Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ahov the Medical Examinar must be notified at 1 **Z**Yes 2 □ No Director MD Worcester Pocomoke City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1503 Market Street 21851 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 XYes 2 ☐ No Maryland 21215-0036 1 ☐ Yes 🍎 No Specify: If Yes, Give Year or Dates: WWII Be Completed by 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) I Hygiene. 12 .. Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tant: If item 27 la markad othar tijury or othar traumatic avant, III Supervisor Lumber & Plywood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Zeno Cox Adeline UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1503 Market St., P.O. Fox 373 Pocyticke, MD 21851 Date 20c. Location - City or Town, State Phyllis Cox (wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. ^ 4 □ Donation 5 □ Other (Specify) Nelson Cemetery 2/12/2006 Poconoke City, ND 22. Name and Address of Facility
Holloway Melson Funeral Home, P.A.
103 Linden Ave., Pocomoke City, MD 21. Signature of Funeral Service Licensee 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Losulin Res /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy j in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 2 No or Attanding Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 70 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred **L** Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death Diractor: / d in by the f 2 Accident 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier ical

JH 3+1

Box 68760.

Records, P.O.

of Vital

Division

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1604 - Market 5%. Locomor

2006

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and manner stated

29c. License number

54422

MD- 21851

29d. Date signed (Month, Day, Year)

Feb. 8. 2006

31. Date filed (Month, Day, Year) FEB 1

29b. Signature and title of certifier

State

Registrar

within 2 To tha

Kevin a. Coons Unpend item#23a,P1,27,penE,0833,3/6/06 IT State of Maryland / Department of Health and Mental Hygiene 06-01282 CT For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day}20 Physician COONS February 10:10 A M KEVIN 2006 A. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Somerset Marion Station 28177 Crisfield Marion Road If Under 1 Year If Under 24 Hrs. 8. Oate of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□F Yrs. Director 212-72-2186 January 16, 1960 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 ☐Yes 2 X No Directo Marion Station Maryland Somerset 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 238 28177 Crisfield Marion Road 21838 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral iteme Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Electronics Repairman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ie marked Nina Rae Bradshaw ဥ Andrew Jackson Coons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if Item 27 ie any injury or other trau once. 28177 Crisfield Marion Road - Marion Station, MD21838 Carolyn C. Parker (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Paul's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2/24/06 Marion Station, MD St. 21. Signature of Funeral Service Coenses

Mary Beth Bradshaw-Pruitt 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, Maryland 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□ Unknown 9 □Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. signé 1 be c Probable Diabetic Ketoacidosis 1 Yes 2 No 3 Probably 4 Nunknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed? 1 Yes 2 🗆 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 Residence 6XXX ther (Specify) Scene ဥ Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME February 21, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registra

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MP

7-2006

32. Registrar's Signature

AWA

31. Date filed (Month, Day, Year)

111 Penn Street Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 1 per doc 8552 2-28-06 vt.

State of Maryland Department of Health and Mental Hygiene () 05937 For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death R. Dow **Harley** Day Year **Physician** Month 6.45 2006 EBRUARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner tofkins 6. Sex 40. DAIT-MACO If Under 1 Year | If Under 24 Hrs.)0h15 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1**X** M 2□ F Director Yrs. FEB 28, Maine 004-24-1747 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow item 27 le marked other than "neturel", or Items 23s or 28a-f ehov other treumatic event, I've Medical Examiner must be motified at 1 ☐ Yes 2 No Director Cecil Maryland E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 37 Jones Chapel Road 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No 1948-If Yes, Give Year or Dates: 1952 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2🏋 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Minister Religion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Harley R. Dow Vera Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit Pages 1 and 2 Department of Health a Important: If item 27 le any injury or other treu <u>Jeanne W. Dow/W</u>ife 37 Jones Chapel Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of cometery, crematory or other place)
Limerick Garden of 20a. Method of Disposition Date 20c. Location - City or Town, State February 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Limerick, * 4 ☐ Donation 5 ☐ Other (Specify) 16, 2006 Pennsylvania Memories 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Aspiration preumonitis
Due to (or as a consequence of): 3 days /Medical Examiner Pulmonary hypertension 4 months Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-transit Parcxysmal rapid atnal fibrillation
Due to (of as a consequence of): 4 months Box 68760, Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has certificate 1 ☐ Yes 2 No 1 Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 No this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After I Certification: 5 Pending investigation 1 X Natural Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a 29a. Certifier 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Medi within 24 To the To the ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) aralllur. MD RES - 000 February 11, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

0.01011

32. Registrar's Signature

Lara Withne, Johns Hopkins Hospital,

FEB 2 8 2006

31. Date filed (Month, Day, Year)

ORIGINAL

600 North Wolfe Street, Baltimore, Maryland 21287

ysicia Medica		Decedent's Name (First, Middle	, Last)			2. Date of Dea		3. Time of Death
		Ruby Josephine	Dobry			Februar	Day Year Year 2006	1:10 P M
amine		4a. Facility Name (If not institution,	, give street and number)		4b. City, Town, or Location of E		4c. County of Dea	
4 .A		St. Mary's Hos	<u> </u>		Leonardtow		St. Mary	
eral		5. Social Security Number 400–26–3905	6. Sex 7. Age (In y	yrs. last birthday) 83 Yrs.		Vin. (Month, Day		rthplace (State or Foreign ountry)
Clor		Usual Residence of Decedent		_05		Feb 10, 1	1922 Ker	ntucky
notified at		10a. State 10b. County	10c.	City, Town or Lo	ocation			10d. Inside City Limits
any injury or other traumatic event, the Mudical Examinar must be notified at once.	Funeral Director	Maryland St. Ma	ary's	Lexingt	on Park			1 Tes X No
	Dire	10e. Street and Number	A . //101		10f. Zip Code		10g. Citizen of What C	ountry?
į.	era	21895 Pegg Road	-	- 11.6	20653		USA	
	Š	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Ever in Armed Forces? ed 1 ☐ Yes 2 ☑ No	110.5.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Whi	
1.	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No Specify:		Specify:	White
	Completed	15. Decedent' (Specify only highest	s Education	16a. Dece	dent's Usual Occupation	atilaa	16b. Kind of Business	/Industry
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	ပ္ပံ	10			Homemaker		Own Home	
	Be	17. Father's Name (First, Middle, L			18. Mother's	Name (First, Middle,	Maiden Sumame)	
1	၉	John Colson Mos		401.44		Tuggle		
1					ng Address (Street and Number o			Zip Code)
	ř	Thomas Dobry / 20a. Method of Disposition		 b. Place of Dispo 	Church Drive G		MD 20634 20c. Location - City or	Town State
		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ☐Removal from State	cemetery, crer loly Face	natory or other place)			
ei I	i	21. Signature of Funeral Service L			Name and Address of Facility		Great Mill	s, MD
	1	In what Hour	in Hardiner	1	Mattingley-Gardi	ner Funeral	Home, P.A.	
		23a. Part 1. Enter the disease, or o	complications that caused the	eath. Do not ent	P.O. Box 270, Le er the mode of dying, such as car	onardtown, M diac or respiratory arr	D_20650 est,	Approximate
ın	İ	shock, or heart failure. List of Immediate Cause (Final		7 - 0	neumonie			Interval Between Onset and Death
al		disease or condition resulting in death)	a. Due to (br as a cons	wan p	40 monie			
er				sequence of)				
		Convention to the test of the con-		sequence of)				
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Carole June Duke 11, 2006 Feb. 3:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kline Hospice House Mt. Airy Frederick If Under 1 Year | If Under 24 Hrs. S. Date of Birth Joneth, Dayles (State or Foreign Vision 1944) 1942 New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 63 Hours 1 M 2 F 149-32-4885 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or iteme 23a or 28a-f ahow traumatic avent, the Mudical Examinar must be notified at MD Frederick Middletown Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Keller Lane 21769 USA Completed by Funera 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes **R**No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

protect 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry personal injury adjuster Elementary/Secondary (0-12) College (1-4or 5+) insurance permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any liqury or other traumatic event Ques. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Douglas L. Preston Anna Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Keller Lane, Middletown, MD 21769 Thomas duke (Husband) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Reformed cemetery2/14/06 ∄ Removal from State 1 □XBurial 2 □ Cremation Middletown, MD 4 Dorfation 5 Other (Spe 21. Signature of Funeral Sar Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inly on-cause on each line. Approximate Interval Between Onset and Death Part1. Enter the disease, or shock, or heart failure. List Imm liate Cause (Final disease condition resulting in death) **Physician** METASTATIC BREAST CANCER 2 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) INPATION 1 ☐ Yes 2 No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) within 24 hours after To the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0056314 FEBRUARY 14, 2006 30. Name address of person who completed cause of death (Item 23a) (Type, Print) JOHNSON DRIVE FREDERICK MD21402 46 B GORGE DINDU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 4 2006 Registrar

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/Medical Examiner	Leonard 1			er)	4b.	City, Town, or	Location of Dea	tebrue	7-1	County of E		Pa W
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Funeral	5. Social Security Num	ber 6. Se	x 7.	Age (In yrs. las	st birthday) If I		If Under 24 Ho	S. 8. Date of E	Birth	9.	Birthplace (State or	Foreign
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death with the Maryland rms 23e or 28a-f show rmust be notified at rerai Director	10e. Street and Numbe					of. Zip Code			10g. Cit	izen of Wha	t Country?	
23e unit	257 N. Bo	ohemia	Ave.			21913			USA			
r items 23e or 28a-f si itrat must be notified funeral Director	11. Marital Status	are service	12. Was Decede Armed Force	s?	13. Was I	Decedent of His , specify Cubar	spanic Origin? (n, Mexican, Pue	Specify Yes or Norto Rican, etc.)	No-		American Indian, Vhite, etc.	
by F	1 ☐ Never Married 3 ☐ Widowed 4 ☐	••	1 ☐ Yes 2 [If Yes, Give Year or Date		1 🗆 Y	es 2 X No	Specify:			Specify: V	White	
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item 2 other	20a. Method of Disposi				e of Disposition	(Name of)	Date	20c. Lo	ocation - City	or Town, State	
ury or	1 XBurial 2 □C 14 □Donation 5 □	Tremation 3 □	Hemoval from Sta)	te	on Ceme	•		18/06	Cec	iltor	ı, MD	
Important: If ite any injury or ot once.	21. Signature of Funer	al Service Licens	800		22. Nar	ne and Address	of Facility	nhein	& Ne	wnam	Funeral	Hom
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	23a. Part 1. Enter the control of the control of the Control of th		ne cause on each	i line.	Do not enter the	mode of dying	, such as cardi	ac or respiratory	arrest,		Approximate Interval Betw Onset and D	een eath
hysician /Medical	Immediate Cause (Fin- disease or condition resulting in death)	ai 🗾	a Cem	ntra		Fart	inson	Fsm			/	
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ě	Sequentially list conditi if any, leading to imme cause. Litter Underlyir Cause (Disease or inju	ions, diate	b. Due to (or a	as a conseque	nce of):							-
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tached hysic	9 Unknown		9□ Unknown									
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10 01								24a. Wa auto	opsy	prior	to completion of car	vailable use of
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Be	25. Was case referred examiner?		Hospital:			Other		ath (Check only			-2240	
r this certificate has ral director, page 2 i: To Be Comp	1 ☐ Yes 2 ☑ No 27. Manner of Death		1 🗀 Inpa	tient 2 EF	VOutpatient 3[Bb. Time of	1004	4 Li Nursing	Home 5 Res			(pecify)	
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ifice		Could not be determined	28e. Place of I	njury - At homi etc. (Specify)	e, farm, street, fa	ctory, office		28f. Location	(Street an	d Number or	Rural Route Numb	er,
	4 (1101110100		building,	etc. (Specify)				City of Te	JWII, State	,		
al Dir			sician: To the be:	st of my knowle	edge, death occu	rred at the time	o, date and place	e, and due to the	e cause(s)	and manner	as stated.	
Funeral Director: After the ly filled in by the funera called Certification:	(Check only 2	Certifying Phy Medicel Exami	ner: On the basis			ation, in mry on						+
mpletely filled in t	(Check only 2 one)	Medicel Exami	ner: On the basis and manner	stated.	- Carlador III dosag			uned at the time	20d De	e signed /##	onth Day Vocal	
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within 24 hou To the Funer completely fill	29b. Signature and title	of certifier	Manner	, M.C	7-	29c. License	number	,	Feb.	nany	13, 2000	Ç
	(Check only 2 one)	of certifier of person who co	Manner	, M.C	7-	29c. License	number	,	Feb.	nany	13, 2000	0670

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month FEB. Day ALMA MAE DORSEY 4, 2006 10:00 AM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Locetion of Deeth 4c. County of Death Examiner Shady Grove Rehab Center Rockville MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F 216-22-7794 84 Yrs Director Nov.29,1921 Maryland Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ortant: if item 27 is marked other than "naturel", or items 23a or 28e-f show Injury or other traumatic event, the Medical Examinar must be notified at Rockville 1 □XYes 2 □ No MD Montgomery Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 end 2 should be filed within 72 hours efter death with the Depertment of Health end Mentel hyglene. Important: If tem 27 is marked other than "many injury or other trauments." 522 Lincoln Street 20850 U.S.A. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 □ No Specify: Specify: Black Be Completed by 3☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10th Homemaker Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas C. Hoy, Sr. Velvia Hoy 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline W. Walker (Daughter) 522 Lincoln St., Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem 2/11/05 Silver Spring,MD 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 246 N. Wash. St., Rockville, MD 20850 120 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cardiac Arrhythmia Instant Examiner Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificete be executed nding physician end use es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of). Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Sick Sinus Syndrome δ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Pneumonia s certificete hes b director, page 2 s 1 Yes 2 3th 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes 2 ☐ No wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural death. 1 Yes 2 No Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours To the Funeral (Hospital *Exertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Timedical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only 29b. Signature and tale of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28656 Feb. 7, 2006 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, 15225 Shady Grove Rd., Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

FEB

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			For	State of Maryla		ent of Health and	d Mental Hy	giene	
			1 - State Registrar		Certific	ate of Death		Reg. No. U	05942
	Physic	ian	Decedent's Name (First, Middle, I	Last)	λ.		2. Date of De Month	Day Ye	3. Time of Death
-	/Medi		4a. Facility Name (If not institution, g	TA TIGNO	es per	ity, Town, or Location of De	2		04 13:30 PM
	Exami	ner	Peninsular Precy	wal medical	Conter S	Salvo Vruru	atn	4c. County of C	CM 11CO
	Funeral			Sex 7. Age (In yr	Mont	der 1 Year If Under 24 P		th 9.	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	1)2	Yrs.		10-12	A. 10h	md.
	yland		10a. State 10b. County	10c. (City, Town or Location				10d. Inside City Limits
	h the Marylan r 28e-f ehow i notified at	ctor	Md Some	rset Pr	incesso	aninic			1 ☐ Yes 2 No
	# 이 제	Funeral Director	10e. Street and Number	1 01 /		Zip Code		10g. Cîtizen of Wha	t Country?
	leath w	erai	11. Marital Status	12. Was Decedent Ever in	115 13 Was Do	21835	/O/- W N	U.	S. A.
9	or Itar		1 Never Married 2 Married	Armed Forces?	If Yes, s	cedent of Hispanic Origin? specify Cuban, Mexican, Pu	erto Rican, etc.)	Black, V	Améncan Indian, Vhite, etc.
5-0036	hours tural',	d by	3 X Widowed 4 □ Divorced	If Yes, Give / \ Year or Dates:	1 U Ye:	S 2 No Specify:		Specify:	Black
15-	na na	Completed	15. Decedent's (Specify only highest of		16a. Decedent's U (Give kind of life. DO NO	work done during most of w	vorking	16b. Kind of Busine	ess/Industry
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	e filed wi al Hygien I other th	Be C	17. Father's Name (First, Middle, Las	st)	TOULE	18. Mother's N	ame (First, Middle,	Maiden Sumame)	ELL Soup
yla	2 should be and Mental ie markad o aumatic eve	70	James (c	Honor		Pear	1 El	norc	
Maryland	12 sh h and 7 ie m traum		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Addr	ess (Street and Number or	Rural Route Numbe	er, City or Town, Stat	e, Zip Code)
	ss 1 and 2 should be filed within of Heelth and Mental Hyglene. Item 27 ie markad other than rother traumatic event, iha Me		20a. Method of Disposition	NSON (daugh	Pace of Disposition (I	Vame of	Date Fri	20c. Location - City	nd, 2/85
E O	Pages ent of nt: If i		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	cemetery, crematory of	or other place)		D_	.or rown, State
Baltimore,	permit. Pages Depertment of Important: If i eny Injury or once.		21. Signature of Funeral Service Lice		22. Name	an Address of Facility B		FINCOSSA	suc ma.
8	88 2 5 8		Miscille	Knings	P.D. D	0x331 Pox	omoka ("itu m	d. 21851
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused the de- y one cause on each line.	ath. Do not enter the m	ode of dying, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ASC	CVO				Onset and Death
	Examiner		1	Due to (or as a conse	equence of):	mall try	,		
	p =	ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	Due to (o. as a conse	equence of):	nellitus			
	and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Lari		ance			
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	tificate g phy: as the	edicai		d.					
Вох	death certific ettending p d for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1□Live birth 2□Fer	nancy tal death 3 Ectopic	organiana.		23d. Date of	delivery
O.E	Physicien: The law requires that the death certif this certificate has been signed by the ettending ral director, page 2 should be detached for use a	Physician/Mo	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown				Month	Day Year
P.0	es that the de gned by the e be detached	Ph.	Part II. Other significant conditions		sulting in the underlying	reques sives in Part I	22a Did to	hann	to the cause of death?
of Vital Records,	quires n sign ald be	d by			g in the different	y oduse given in Faith.			Probably 4 Unknown
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æ	The L	E O					autops perfor 1 ☐ Yes	med? prior i	to completion of cause of
/ita	sicien: T certificat rector, pa	Be	25. Was case referred to medical examiner?			26. Place of De	eath (Check only or	-	65 2 140
of	Physi this o	ြို	1 ☐ Yes 2 ☐ No 27. Manner of Death		ER/Outpatient 3 1		Home 5□ Reside	ence 6 □Other (S	оөсііу)
0	ing fa	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred	
Division	Attendi or death. ector: A by the fu	Certification;	3 Suicide 6 Could not to determined	28e. Place of Injury - At h	nome, farm, street, facto		28f. Location (Si	treet and Number or	Rural Route Number,
Ö	ital or rs efte al Dir led in	Cert	4 - Hornicide	building, etc. (Speci	ify)		City or Town	n, State)	
	Hospi 14 hou Funer Tely fill	edicai	29a. Certifier 1 Certifying P	hysician: To the best of my kn	owledge, death occurre	ed at the time, date and place on, in my opinion, death occ	e, and due to the c	ause(s) and manner	as stated
	To the within 2 To the c. mple	Med	29b. Signature and title of certifier)	and manner stated.		9c. License number		9d. Date signed (Mo	
			1.6.2	(1)		D7154	6	2/10/	07
-	y M		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type; Print)	1371396 ms	Pan	-1-7	~0.
	1		Contract of the Contract of th			MI	1. 10016	190 €.CA	PRAVIL ST
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature A A A A A			SAL	isbury md.

218-30-1270

Dennis

		-	For State Registrar		State	of Maryla	and / Dep <i>Ce</i>	artmen rtificate			ınd Me		iene .g. No. () ()	6	05943
	q		1. Decedent's Name (F	irst, Middle, Las	t)							2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic		John	AI	o sche	tti						Feb.	T	006	8,47 AM
	Examin		4a. Facility Name (If no	t institution, give	street and nu	ımber)	,	4b. City,	Town, or	Location o	f Death		4c. County		0
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	Funeral Director		5. Social Security Number 130 26 555	4	ex M 2□F	7. Age (In y	rs. last birthday, Yrs.	If Under Months	Days	Hours	Min. F	8. Date of Birth (Month 12y, eD. 12,	^Y 1933	New	place (State or Foreign TOTK
	pu 🛾		Usual Residence of De 10a. State 10	b. County		10c.	City, Town or L	ocation						T	10d. Inside City Limits
	within 72 hours after death with the Maryland ene. than "natural", or liems 23a or 28a-f show fra Modical Examilier court be motified at	ō	MD	Howar	4		columbia								1 ☐ Yes 2 ☐ No
	the N	ect	10e, Street and Numbe				-	10f. Zip	Code			1	0g. Citizen of	What Cou	ntry?
	with	Funeral Director	9420 Ridge		ive				210)46			USA		
	ns 23	era	11. Marital Status		10.111	cedent Ever in	1 U.S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Spec	cify Yes or No- lican, etc.)			ican Indian,
	r Iten	Fun	1 Never Married	2 Married	Armed F	orces?	953-	If Yes, spec	**		, Puerto H	lican, etc.)		ck, White	
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JZ.	d 2 should th and Men 7 is marke traumatic	-	19a. Informant's Name	₃/Relationship (Type, Print)		19b. Mail	ing Address	(Street a	and Numbe	r or Rurai	Route Number	City or Town	State, Zi	ip Code)
	2 = 24 -		Eleanor F	oschett	i/ex-w	ife	943	31 Bul	llrir	ig Lai	ne C	olumbia	ı, MD	2104	5
re,	f Heal itam 2 othar		20a. Method of Disposi		ID	201	b. Place of Disp cemetery, cre	osition (Nar	ne of other plac	e) !	Da	ate	20c. Location	- City or T	own, State
E	Pages nent of I ant: If its ury or o		1 XBurial 2 □ C 14 □ Donation 5 [1 State	rest La			4	2/14	/2006 M	Marriot	tsvi	lle, MD
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funer	ral Service Licer	S88										ily FH Inc.
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			23a. Part 1. Enter the c shock, or heart fa	disease, or com ailure. List only	plications that one cause on	caused the deach line.	eath. Do not er	iter the mod	le of dyin	g, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
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	/Medical		resulting in death)	(Due to	o (or as a cons	s to ence of):	0							0
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_	and and I-tran	Examiner	that initiated events resulting in death) Las		c	o (or as a con:	sequence of):				-			-	
60	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ical E		ı											
09289	physicate s the				d										
×	certif nding use a	/Me	IF FEMALE: 23b. Was decedent pr	reconant		utcome of pre							23d. Da	ate of deli	very
Вох	death certifics attending pt d for use as t	Physician/Med	in the past 12 mg	onths?	4⊡Pre	birth 2 🔲 F gnant at time (□Ectopic pi □ Other (sp					М	onth	Day Year
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<u>o.</u>	es that igned b	by P	Part II. Other significa	int conditions	ontributing to	death but not	resulting in the	underlying o	cause giv	en in Part I					the cause of death?
ĕ	v require been sig should b	ed t	Obstructive	Sleep	Opne	, Chro	mic C	BANC	tive	Polin	Course	1 DX	es 2□No	3 □ Pro	bbably 4 Unknown
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of V	Physician: r this certificanal director, i	20	1 ☐ Yes 2 ☐ No		Hospital: 1	Inpatient 2	2 ER/Outpation			4 LI NU		ne 5 🗆 Resid			ify)
	ding PI h. After th funera		27. Manner of Death 1 Inatural	5 Pending	28a. Dat (Mo	e of Injury onth, Day Yea	r) 28b. Time Injury		28c. Injun Wor			8d. Describe h	ow injury occu	rred	
Sio	death. ctor: A y the fu	cati	2 Accident 3 Suicide	investigatio				M	_	Yes 2 🗆		of Location /S	treet and Num	ber or Ru	ral Route Number,
Division	or Atl after d Diract in by	Certification;	4 Homicide	determined	286 Pla	ce of Injury - A Iding, etc. (Sp	At home, farm, s ecify)	treet, factor	у, опісе			City or Tow	n, State)	<i>Der 01 11</i> 4	iai modio mamber,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ledical C	29a. Certifier 1[(Check only 2[one)	☐ Certifying PI	niner: On the	he best of my basis of exam	knowledge, dea nination and/or	ath occurred investigation	l at the tin	ne, date ar pinion, dea	nd place, a ath occurre	and due to the o	ause(s) and m late and place	anner as , and due	stated. to the cause(s)
	thin 2 the 3 the	Med	29b. Signature and titl	le of certifier	and the	stateu.		29	c. Licens	e number		- 2	29d. Date sign	ed (Month	n, Day, Year)
	Z W		12	2/11		non (04	6120	\supset		Feb.	10,	2006
			30. Name and address	s of person who	completed ca	use of death	(Item 23a) (Type	e, Print)					-		
١٢١	1a2		F De L	em	1072	4 Litt	le Petur		Pkwa	1,	010-	50	900	210	44
•	St Regist	ate rar	31. Date filed (Month,	1 1		Registrar's S		donali	ر						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item, 8,9 per land 8852,2 2-28-06 Hyth and Mental Hygiene

			Amend i 1 - State Registrar	ten 8 9 pe	iryland		2-28 artmen rtificat			and M		giene Reg. No.	06	05944
П	Physicia	an	1. Decedent's Name (First, Middle, Last		וויידייוו						2. Date of De. Month	Day	Year	3. Time of Death
<u></u>	/Medic Examin	al	4a. Facility Name (If not institution, give		LIIU		, ,	Town, or	Location o	of Death	FEBRUA	4c. Co	2006 unty of Death LLEGAN	
l	Funeral Director		E Cooled Coought Number 6 Se	x 7. Age	(In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da 2-2-22	th y, Year)	9. Birth Cou MI	nplace (State or Foreign untry)
	e Maryland se-f ehow illica at	ctor	Usual Residence of Decedent 10a. State 10b. County MARYLAND ALLEGANY			, Town or Lo	URG							10d. Inside City Limits 1 Yes 2 □ No
:	with the or 26	Directo	10e. Street and Number 172 ORMOND STRE	7 TT			10f. Zip	2153	22			10g. Citizen	of What Co	untry?
020	filed within 72 hours after death with the Maryland Hygiene. other then "naturel", or liems 23c or 28e-f ehow ent, the Medical Exertine Invasible notified	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 X N If Yes, Give Year or Dates:	Ever in U.S		Was Decedif Yes, spe	dent of Hi cify Cuba	spanic Ori	ı, Puerto i	cify Yes or No Rican, etc.)	- 14.	Race - Amer Black, White	
0000-0171	within 72 hou ane. then "nature he Medical E	Completed	15. Decedent's Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	+)	life.	dent's Usu kind of wo DO NOT u	se retirea	du <i>rina m</i> os	t of worki	ng		of Business/I	ndustry
	8 <u>a</u> a	o Be Co	17. Father's Name (First, Middle, Last) MICHAEL GRIMES		1						(First, Middle		mame)	
	iges 1 and 2 should be to of Health and Mental to frem 27 is marked or or other traumetic ev		19a. Informant's Name/Relationship (7 WILLIAM M. GRIFFI'			172	ORMOI	ND ST		FROS	STBURG	MD 215	532	
ຍ	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		20a. Method of Disposition 1			ace of Disposit			PARI		-17-06		ion - City or TBURG	
Dall	permit. Departn Importe eny inju		21. Signature of Funeral Service Licen	JOET MO	0547		OWERS	s FUN	ss of Facilit	HOM	E. P.A.	FROST		STREET MD 21532
E.	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	one cause on each lin	phow a consequ	1A O	0		ices t			nest,		Approximate Interval Between Onset and Death
9/00,	eath certificate be executed attending physician and for use as the burial-transit		that initiated events resulting in death) Last	Due to (or as a	a consequ	ience of):								
O. BOX 6	0 0	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3[⊒Ectopic p ⊒ Other (s)					230	. Date of deli Month	very Day Year
ras, P	w requires that the de- been signed by the a should be detached f	by	Part II. Other significant conditions of	. 1 6 3	ut not resu	ulting in the u	4 1	cause giv	_			tobacco use Yes 2 1		the cause of death? obably 4 Dunknown
Vital Records,	Physician: The law requires that the this certificate has been signed by the director, page 2 should be detach	Completed									24a. Was auto perfe 1 \(\text{Yes}		24b. Were au prior to death?	topsy findings available completion of cause of
IIa	cian: ertifica actor, I	Be	25. Was case referred to medical examiner?	Hannital.				Oth			(Check only			
ō	fter fter iner	lon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatie		28b. Time of Injury		28c. Injur Wor	4 🗀 140		me 5 Resi 28d. Describe			cify)
DIVISION	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At ho c. (Specify	me, farm, st	reet, factor	ry, office			28f. Location (City or To	(Street and f wn, State)	lumber or Ru	ıral Route Number,
	ne Hospit ne Funere detely fille	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of and manner sta	examinat	wledge, dea tion and/or in	th occurred ivestigation	d at the tir n, in my o	ne, date ar pinion, dea	nd place, ath occurr	and due to the red at the time,	date and pl	ace, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	ha-	M	0	29	c. Licens	e number	775		29d. Date s	igned (Monti	h, Day, Year)
	6		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type	, Print)	VOC	700	(1	n	reo	522	-006
		ate	31. Date filed (Month, Day, Year)	MO 4°	o Ta ar's Signa	ture	rac	e	109	thu	rg M	IV 4	05-	

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Dep 1- State Amend Items 25,27,28a-f per	partment of Health and I Fruit Case of Death		A 197 O 10 O 0
	Physici /Medic		Decedent's Name (First, Middle, Last) SYLVIA R. GARVIN			Day Year 3. Time of Death 3. COO 11. 50 9 M
	Examir Funeral	ier	4a. Facility Name (If not institution, give street and number) MANOR CARE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 0.5.2—1.6—8.6.6.3 1 □ M 2 ☒ F 84 Yrs.	4b. City, Town, or Location of Death WHEATON / If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	4c. County of Death MONTGOMERY 9. Birthplace (State or Foreign Country)
	Director wove	or	052-16-8663 Usual Residence of Decedent 10a. State 10b. County MARY LAND MONTGOMERY	ocation CHEVY CHASE	12/06/1921	NEW YORK 10d. Inside City Limits M☐ Yes 2 ☐ No
	with the N Se or 28a-f	I Director	10e. Street and Number 8566 FREYMAN DRIVE	10f. Zip Code 20815	10g.	Citizen of What Country? U.S.A.
920	72 hours after death with the Maryland natural', or items 23a or 28a-f ahow Jisal Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Drorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race · American Indian, Black, White, etc. Specify: WHITE
21215-0036	yene.	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of wor DO NOT use retired) IFEACHER	tking 16b	. Kind of Business/Industry EDUCATION
Maryland	should be filed nd Mental Hygid marked other umatic avant, II	To Be C	17. Father's Name (First, Middle, Last) JOSEPH BLEIFIELD	ANNA I	ne (First, Middle, Maid ICHTMAN	
	es 1 and 2 should b of Health and Ment of Item 27 is marked or other traumatics			HUDSON STREET, HO	BOKEN, NJ	ty or Town, State, Zip Code) 07030 Location - City or Town, State
Baltimore,	Par Hand		1 ⊠Burial 2 □ Cremation 3 ☑ Removal from State 4 □ Donation 5 □ Other (Specify) MT MORIA	ematory or other place)		AIRVIEW, NEW JERSEY
Ba	Departition of the point of the		23a. Part 1. Enter the disease, or complications that caused the death. Do not e	ANZANSKY-GOLDBÉRG 170 ROCKVILLE PIKE	, ROCKVILI	CHAPELS, INC. JE, MARYLAND 20852 Approximate Interval Between
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	biratory arre. artery disea	st per l	Onset and Death
0,	ate be executed hysician and he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):		Mal	
68760,	tificate being physicias the bu	fedical	d	AERTIFICA .	MON APPROVED BY MET	DICAL EXAMINER
P.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and ogge 2 should be detached for use as the burial-transit	Physician/Med		B⊟Ectopic pregnancy B ☐ Other (specify)		23d. Date of delivery Month Day Year
Records, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the A Chaines dementia	underlying cause given in Part I. — hyper Gipide,		co use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☒Unknown
	nysician: The law r his certificate has be I director, pege 2 sh	Completed			24a. Was an autopsy performed 1 Yes 2	
Division of Vital	ding Pl h. After ti funera	ation; To Be	25. Was case referred to medical examiner? 1	ent 3 DOA Cther: 4 Nursing H	28d. Describe how i	
Divis	To the Hospital or Attent within 24 hours efter deatl To the Funeral Director: completely filled in by the	Certification:	3 □ Suicide 6 □ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify) at home		8566 Frey	nan Drive, Chevy Chas
	tha Hosp thin 24 ho the Fune mpletely fi	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the bast of my knowledge, de (2 Medical Examiner: On the bast of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occurred as License number	urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Dey, Year)
	3		30. Name and address of person who completed cause of death (Item 23a) (Typ	D 2005530	167000	2-3-06 Kaiser termont
e,	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 1 3 2006 32. Degistrar's Signature	parti		_

		1 - For State Registrer	te of Maryland / De	partment of H <i>ertificate of I</i>			iene •9. No. 0 0 6	05946
Physicia	n	Decedent's Name (First, Middle, Last)				2. Date of Dea	th 8,0ay 2006 Year	3. Time of Death
/Medica Examine	al .	LILLIAN GOLD 4a. Facility Name (If not institution, give street a HEBREW HOME OF GREATER		4b. City, Town, or ROCKV	Location of Deeth		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. last birthdom) 95 Yrs	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day AUGUST 2	Year) Cour	place (State or Foreign ntry) IIGAN
Maryland f show	ior	Usual Residence of Decedent 10a. State 10b. County MARYLAND MONTGOMERY	10c. City, Town of				1	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the	Director	10e. Street and Number	ADT COC	10f. Zip Code		1	log. Citizen of What Cou	ntry?
Nore, Maryland 21215-0035 ges 1 and 2 should be filed within 72 hours after death with the Maryland 1 of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examination in this idea.	by Funeral	1 Never Married 2 Married 1		20906 3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: CAU	etc.
Maryland 21215-0036 nd 2 should be filed within 72 hours aff lith and Mental Hygiene. 27 is marked other than "natural", or rtraumatic event, the Mudical Exert	Completed	15. Decedent's Education (Specify only highest grade complete comp	pleted) (G	cedent's Usual Occup ive kind of work done of e. DO NOT use retired LIBRARIAN	during most of wor		16b. Kind of Business/In	
Vland Z wild be filed Mental Hygi arked other atic event, il	To Be Co	17. Father's Name (First, Middle, Last) MAX SCHWARTZ				ne <i>(First, Middle, I</i>		
Mary and 2 sho alth and 1 27 Is ma er traums		19a. Informant's Name/Relationship (Type, Pr. WYNNE SITRIN - GRANDDAUGI		ailing Address (Street :			r, City or Town, State, Zip	o Code)
Baltimore, be mit. Pages 1 a De artment of Hee my originary or othe		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ Remova 1 □ Donation 5 □ Other (Specify)	al from State cemetery, o	sposition (Name of crematory or other plac ION CEMETERY	1	Date 0/2006	20c. Location - City or To	own, State
Baltimo		21. Signature of Funeral Service Licensee Myslint. Wls	leil	22. Name and Address	11.		DI FUNERAL HOM VER SPRING MD	
	dical Examiner	Sequentially list conditions, if any, leading to immodate cause. Enter Underlying Cause (Disease or injury that initiated events	carpione to (or as a consequence of): Oue to (or as a consequence of): Oue to (or as a consequence of):					Interval Between Onset and Death 1 YEAR
death certific	by Physician/Mec	in the past 12 months?	res, outcome of pregnancy]Live birth 2 ∏Fetal death]Pregnant at time of death]Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deliv Month	ery Day Year
Ords, P.O requires that the sen signed by th		Part II. Other significant conditions contributi RENAL FAILURE	ng to death but not resulting in th	e underlying cause giv	en in Part I.		bacco use contribute to t es 2.⊠No 3.⊟Prol	
Rec The law ate has b	Completed	DIABETES				24a. Was a autops perfor 1 □ Yes	sy prior to co	opsy findings available impletion of cause of
Of Vital I Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospita	il: 1 ☐ Inpatient 2 ☐ ER/Outpa	tient 3 DOA Oth	or	ath <i>(Check only or</i> Iome 5 ☐ Resid	ne) ence 6 □Other (Speci	fv)
	atlon; To		n. Date of Injury 28b. Tim (Month, Day Year) Inju	e of 28c. Injur	y at		ow injury occurred	,,,
Division all or Attending s after death. al Director: Afte	Certification:	3 Suicide 6 Could not be 4 Homicide determined 286	Place of Injury - At home, farm building, etc. (Specify)	street, factory, office		28f. Location (S City or Town	treet and Number or Run n, State)	al Route Number,
ne Hospital of the Hospital of the Funeral Collector filled in the Hospital Collector filled in the	edical ((Check only 2 Medical Examiner: C	To the best of my knowledge, d in the basis of examination and/o and manner stated.					
To the within 2 To the complete	Me	29b. Signature and title of certifier Lecce	Deconil	29c. Licens	e number 36716	2	29d. Date signed (Month, 2/8/2006	Dey, Year)
4		30. Name and address of person who complet	ed cause of death (Item 23a) (Ty	pe, Print)			-, -, 2000	
Sta Registra		ANDREW KUNDRAT, M.D. 6 31. Date filed (Month, Day, Year) FEB 1 0 2006	121 MONTROSE ROAD, 32 Registrar's Signature		20852			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. UUS 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Mary Jane Gates Feb.9,2006 7:35a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 5-E Laurel Hill Road Greenbelt Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1/06/1936 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 ☐ M 2X F 191-28-2850 70 Yrs. Director Johnstown, PA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location r than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 10d. Inside City Limits MD Prince George's Greenbelt Director 1 ☐ Yes 🎇 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5-E Laurel Hill Road 20770 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "natural", or its any injury or other traumatic avant, the Medical Examilrasonce. 1 ☐ Yes 27 No If Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Specify. Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher 5 +Montgomery County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Calvin Gates Margaret Richardson 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lu Price/Friend-P.O.A. 5-E Laurel Hill Road Greenbelt, Md 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Chesapeake Crem. 2/10/06 Beltsville, Md 4 Donation 21. Signature of Funeral Service Ucensee 22. Name and Address of Facility PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Adenocarcinoma Abdomen /Medical Due to (or as a consequence of) Examiner Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Probable Sesis Due to (or as a consequence of): Box 68760 the attending physicien Physician/Medical as the l IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year 5 Other (specify) Records, P.O. detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe Completed 1 ☐ Yes 2 ➡No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? certificate Division of Vital 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 🔲 Inpatient 2 ER/Outpatient this 3 DOA After this 28a. Date ol Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death.
I Director: Aft
d in by the fur investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours aft to the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD H 45523 Feb.9,2006 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Burkett 11000 New Hampshire Ave. Silver Spring, Md 20904 MD 31. Date filed (Month, Day, Year) 32. Signature State FEB 1 0 2006 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of I	Marylan		irtment <i>tificate</i>			ind Me	ental Hygi Rei	ene 3. No. 0 0	6	05948
- 3	Physicia	an	1. Decedent's Name (First, Middle, Last Karl W. Gabsch)							2. Date of Death Month February		Year N.S.	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	street and number	9r)		4b. City, T	Town, or	Location of		ebruary	4c. County of		
	Examin	er	Holy Cross Hospi						Sprin	4.5		Monte	<i></i>	
1	Funeral Director		5. Sociał Security Number 6. Se 577-03-5983	x 7.] M 2 ☐ F	Age (In yrs. 91	last birthday) Yrs.	ff Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day, NOV 4	1914	9. Birth Cor Was	pplace (State or Foreign intry) shington, DC
	D D		Usual Residence of Decedent 10a, State 10b, County		10c Cit	v. Town or Lo	cation							10d. Inside City Limits
	Maryla f ehov	٥	Maryland Montgome	rv		ver Sp								1 ☐ Yes 2 ☐ No
	or 28a-	Directo	10e. Street and Number				10f. Zip				10	g. Citizen of W		•
	ath wit		9900 Gardiner Ave		17	0 1.01	209			-:-2 (6		14 9000		SA ican Indian,
36	be filed within 72 hours after death with the Maryland ald Hygiene. Ad other then "natural", or items 23a or 28a-f ehow other then "natural", or items 23a or 28a-f ehow event. The Medical Examination must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 X Yes 2 If Yes, Give Year or Date	s? □No	'	Was Decedon fYes, spec 1 ☐ Yes 2	ify Cubar	Specify:	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		, White	, etc.
ל ב	72 hou natura ilgal E	ted	15. Decedent's Edu (Specify only highest grad	ication		(Give	ient's Usua kind of wor	k done d	urina most	of working		6b. Kind of Bus	siness/l	ndustry
	filed within Hygiene.	Completed	Elementary/Secondary (0-12)	Coflege (1-4	or 5+)		no NOTus no Bu		_			Trans	por	tation
Maryland 21215-0036	filed v i Hygie other i	Be Co	17. Father's Name (First, Middle, Last)			1100	TO Bu			r's Name	(First, Middle, M	_	-	0.0000000000000000000000000000000000000
ylan	should be and Mental marked c	To B	Charles Oscar Ga	absch							ry Naeh			
Zan	C/ c/ - c/		19a. Informant's Name/Relationship (7)			1	•				Route Number,			
ē,	s 1 and f Health itam 27 other to		20a. Method of Disposition	on	1 0	2820 Place of Disponentery, cren	sition (Nam	ne of		Da		Oc. Location - (0603-4900 Fown, State
Ē	Pages nent of ant: If it		1 ☐ Burial 2 TCremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		1 91	tropolit			1 -			lexand:	ria	. Virginia
Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licens	Cole		Fr: 500	Name and and and and and and and and and and	J. Vers	s of Facility Colli ity B	ns Fu	uneral H W, Silv	lome In	c ing	, MD 20901
7			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	heations that cau ne cause on eac	sed the deat h line.	h. Do not ent	er the mode	e of dying	g, such as	cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Q	emic R	espira	tory :	Fail	ure				-	1 Hour
**************************************	Examiner					Pneumoi	nia							24 Hours
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	U	as a conseq									
	be executed sicien and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):								
8760	cate be executed obysicien and the burial-transit	dicai E	(d										
Õ	ertifica ling ph		IF FEMALE:	220 If you outon	mo of orogon	1001						004.0	-4-6	
O. Box	at the death certific by the attending p tached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outco 1⊟Live birth 4⊟Pregnan 9⊟Unknow	n 2 ∏ Feta it at time of d	I death 3	Ectopic pro					23d. Date Mon		very Day Year
rds, P.	quires that n signed b uld be deta	þ	Part fl. Other significant conditions co	ntributing to deat	th but not res	ulting in the u	nderlying ca	ause give	n in Part I.					the cause of death?
Division of Vital Records,	The law requires that the cate has been signed by the page 2 should be detache	Completed									24a. Was an autopsy perform	ed? d	rior to o	topsy findings available completion of cause of
/ita	nysician: Th nis certificate I director, pag	Be	25. Was case referred to medical examiner?	Hospitaf:				Othe			(Check only one			
6	S D		1 Yes 2 XNo 27. Manner of Death	28a. Date of (Month,		ER/Outpatier 28b. Time o		8c. Injury	at		e 5 Resider			cuty)
0	tending Phasth. tor: After the	atior	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year)	fnjury	М	Work	i? Yes 2 🗆 I	No				
Divis	al or Attend s efter death il Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	289. Place of	Injury - At h	ome, farm, str	eet, factory	, office		2	8f. Location (Str. City or Town,	eet and Numbe State)	er or Ru	ral Route Number,
	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	edicai (23a Gettler (Check only one) 1∑ Gertifying Phy 2 ☐ Medical Example 1		is of examina									
	To t To tl	Σ	29b. Signature and title of certifier	100000	0	111	290	License	number		29	d. Date signed Februa		h, Day, Year) 7, 2006
•	511		30. Name and address of person who concerns the Nowak, N		of death (fter	n 23a) (Type, est G1	Print) en Ro			er Sp	ring, MI	-	- J	
	Sta	te.	31. Date filed (Month, Day, Year)											
3	Registi		FEB 102	006	34000 1	ature								

			For State Registrar	State of Marylai	•	artment o			Hygie Reg.	211111	5	05949
	Div. dist		1. Decedent's Name (First, Middle, Last)					2. Date	of Death	Day Y	/eer	3. Time of Death
	Physici /Medic			Elizabeth	Horst			Febru		18 2006	5	4:30 P. M
	Examin		4a. Facility Name (If not institution, give	street and number)			n, or Location	of Death		4c. County of Washi		on
			Mennonite Home 5. Social Security Number 6. Securi	7. Age (In yrs	last hirthday	If Under 1 Ye	rstown ear If Under	24 Hrs. 8. Date	of Birth			olace (State or Foreign
	Funeral Director			M 201 99	Yrs.	Months Da		Min. (Mon	of Birth th, Day, Yo L 17	9ar) 1906	Cour	yland
TO			Usuel Residence of Decedent									
arylar	Show	-	10a. State 10b. County	_	ity, Town or L lagerst							0d. Inside City Limits 1 ☐ Yes 2 X No
e X	28a-f	ecto	MD. Washingt		ageist	10f. Zip Cod	lo.		100	. Citizen of Wh	at Cour	
d 21215-0036 , ifled within 72 hours after death with the Maryland	The n	by Funeral Director	13436 Maugansvill	e Rd.			1740		1	U.S.A.	iai coui	itty:
death	ms 23	era	11. Marital Status	12. Was Decedent Ever in I	J.S. 13.	Was Decedent	of Hispanic Or	igin? (Specify Yes n, Puerto Rican, et	or No-	14. Race -		
after 6	or fte	Ē	1 Never Married 2 Married	Armed Forces? 1		1 ☐ Yes 2 🛣			(C.)	Specify:	White,	
003	Exs.	d b	3 X Widowed 4 □ Divorced	Year or Dates:					1			
12 12 12 12 12 12 12 12 12 12 12 12 12 1	nat adles	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Oc kind of work do DO NOT use re	ne during mos	t of working	16	b. Kind of Busi	iness/In	dustry
12 de ja	than	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		nemaker	,			Home		
D bell	other	BeC	17. Father's Name (First, Middle, Last)					er's Name (First, A		iden Sumame))	
ja	Menta rrked tric e	ToE	Abraham E	. Horst			An	nie M. Sl	hank			
Maryland 21215-0036	Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, the Medical Examiner must be notified at 9008.		19a. Informant's Name/Relationship (Ty Lydia Rudolph/Da					Rd. Gre				
. s 1 a	item item		20a. Method of Disposition	20ь.	Place of Disponent	osition (Name o	place)	Date		c. Location - C	•	
mc Page	nent c		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	emoval from State Mi	llers N urch Ce	matory or other Mennonit emetery	e	2/22/06	L	eitersl	ourg	g, Md.
Baltimore,	Depart Import any inje		21. Signature of Funeral Service Licens H. Marten: 21	mem Ti	$\frac{Z^2}{4}$	2. Name and Ad Lmmerman	dress of Facili n And S clisle	on Funer St. Gree	al Ho ncast	me Inc le, Pa	: 17	225
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the dea ne cause on each line.								Approximate Interval Between
	ysician		Immediate Cause (Final disease or condition	Cruer	two h	earl L	melon					Onset and Death
	Medical kaminer		resulting in death)	Due to (or as a conse	quence of):	0		- /				
		-	Sequentially list conditions,	Due to (or as a conse	guence of):	can	van	les dia	enso			gens.
1 5	Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,							
exect	in and	Exa	resulting in death) Last	Due to (or as a conse	quence of):					<u> </u>		
8760 , <i><</i> cate be executed	physician and s the burial-transit	dlcal	L.	1								
riffica		Med	IF FEMALE:									
of Vital Records, P.O. Box 6 Physician: The law requires that the death certific	ed by the attending detached for use as	by Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1☐Live birth 2☐Fet	aldeath 3	Ectopic pregna				23d. Date Month		ery Day Year
O 을	the a	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (specify	")					
Division of Vital Records, P.O. I or Attending Physician: The law requires that the d	ed by detac	'Ph	Part II. Other significant conditions con	ntributing to death but not re	sulting in the t	inderlying cause	given in Part I	. 23e	. Did tobac	co use contrib	ute to t	he cause of death?
Spun	sbeen signed I should be det	d b							1 🗆 Yes	2 X No 3	☐ Prob	pably 4 ⊡Unknown
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2 2	te has	E O						10	autopsy performe Yes 2	d? de	ath?	mpletion of cause of 2□ No
	ortifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place	of Death (Check				
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on o	After t	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		njury at Work?		cribe how	injury occurred	1	
isic tend	death.	lcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At I	nome farm st		1 ☐ Yes 2 ☐		tion (Stree	at and Number	or Rura	al Route Number,
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Division To the Hospital or Attending	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page			; slcian: To the best of my kn ner: On the basis of examin								
the H	the Fu	Medical	one)	and manner stated.	and and of It			an occurred at the				
To	To Con	2	29b. Signature and title of certifier				ense number			Date signed (
				Her un		7	nD-60	7487 6		FER 2	0,	2006
	2		30. Name and address of person who co	mpleted cause of death (Ite 1964 BUCHAN Registrar's Sign	m 23a) (Type FN TRA	RL R. S	HADY	GROVE.	PA.1	7258		
3.	Sta	ate	31. Date filed (Month, Day, Year) 200	32 Registrar's Sign	ature /	rels)						
	Registi		LER X 8 500	AND THE STATE OF	The same of the sa	distribute.						

within 24 hours a To the Funarai I Medical (Check only one)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Insert Section 1] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D58755 29d. Date signed (Month, Day, Year) 2/9/2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9714 Healthway Drive, Bertin, MD21811

Glenn K. Arradon, M.D.

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760,

Records, P.O.

Division of Vital

death.

31. Date filed (Month, Day, Year) FEB 1 4 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Unpend#1,23a,27, pen/F (853,3/13/06 TT alth and Mantal Hydrians

ат		1 = For State Registrar	State of Ma	afyl and'/ Depa <i>Ce</i>	antment of F rtificate of		Mental Hy	giene Reg. No.	106	05951
Phys		Decedent's Name (First, Middle, L STEVEN NELS	Steven I	Nels Hiortdah	1		2. Date of De Month	eath Day	Year	3. Time of Death
/Me Exan	dical niner	4a. Facility Name (If not institution, g			4b. City, Town, o	r Location of Death	Februa		5, 2006 ounty of Death	5:06 P [™]
Funera Directo		Washington Count 5. Social Security Number 6. 508-76-4116	43775V2 0 C T E	e (In yrs. last birthday) 49 Yrs.	Mt. Air If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di OCT • 22	rth av. Year)	edrick 9. Birtho	olace (State or Foreign htry) WARE
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
Mary	ţċ	MARYLAND CARRO	OLL	MT. AIRY	7					1 ☐ Yes Ş ∰No
h with the 3a or 28 st be not	i Director	10e. Street and Number	BRANCH RD		10f. Zip Code 2177	7		10g. Citize	on of What Cour	•
lore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natursi", or Items 23a or 28a-1 show or other traumatic svent, the Medical Exacultrar results notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent I Amed Forces? 1 □ Yes 2 ☒ N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No		pecify Yes or No o Rican, etc.)		U.S.A Race - Americ Black, White, pecify: WHI	an Indian, etc.
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within than	dwo	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retired	•			~ ~	
laryland 2 2 should be filed and Mental Hygi is marked other aumatic syste, ii	Be C	17. Father's Name (First, Middle, Las		НҮГ	ROLOGIS	18. Mother's Nan	ne (First, Middle		.G.S. umame)	
arylar should b ind Menta i marked umatic s	To	THEODORE NELS	HIORTDAH	- -		MARY L	OUISE	LONG		
Mar 12 sh h and h and 7 ls m traum	10	19a. Informant's Name/Relationship MARY LOU HIORT			ng Address (Street			•	,	•
re, N 1 and 3 Health tem 27		20a. Method of Disposition	DAHL-MOTE	20b. Place of Dispo	sition (Name of		LA PLA		MARYLA ution - City or To	ND 20646 wn. State
altimore, mit. Pages 1 ar partment of Hea portant: if Item y injury or othe		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Cemetery, crer	natory`or other plac 'HIIRCH C	1	1-06		Y, MAR	
baltimore, permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other		21. Signature of Funeral Service Lie	MO()479 (/22	RAYMOND	s of Facility FUNERA	L SERV	ICE,		ILAND
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The tav	Com						perfo	rmed?	death?	
OI VIKALIT Physician: Th this certificeteral director, pag	Be	25. Was case referred to medical examiner? 1 Types 2 No	Hospital:		Othe	26. Place of Dea				
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s Hospi 24 hou s Funer letely filt	edical	29a Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner stat	examination and/or inv	restigation, in my op	a, data and place, inion, death occur	and due to the red at the time,	causa(s) ar date and pla	d mann of as str ace, and due to	ated. the cause(s)
To th To th comp	₩ We	29b. Signature and title of certifier			29c. License	number		29d. Date s	igned (Month, L	Day, Year)
		1 auch			OCME			Febru	ary 16,	2006
		30. Name and address of person who			Print)				and the same of the same	
2	tate	ANA RW 31. Date filed (Month, Day, Year)			111 Penn	Street,	Baltimo:	re, Ma	aryland	21201
Regis		FEB 2 7 20	06 Deline	r's Signature						
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			1 - For State Registrar	State of M	arylan	d / Depa		of He		_		9000	n5952
	Physic	ion	1. Decedent's Name (First, Middle,	•						2. Date of D	eath		3. Time of Death
	/Medi			lexander Ha	ight					Feb.	12 ^{Da}	2006	10:00P [™]
	Exami	ner	4a. Facility Name (If not institution, Atlantic Genera					own, or l 'lin	Location of Deat	th		orcester	
	Funeral				e (In yrs. I	last birthday)	If Under 1	Year	If Under 24 Hrs	8. Date of B			place (State or Foreign
	Director	ı	140-16-2542	1 ℃ M 2□ F	94	Yrs.	Months	Days	Hours Min.	8. Date of B	25, T	911 NY	ntry)
,	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						0d. Inside City Limits
	Mary	tor	MD Worces	ter		ean Pi							1 ☐ Yes 2X No
	th the or 28a	irec	10e. Street and Number				10f. Zip C	Code			10g. Cit	tizen of What Cour	ntry?
	death with the Maryland ms 23a or 28a-f show	Funeral Director	1135 Ocean Parkw	ay			21	811			US		
0	ter de items	une	11. Marital Status	12. Was Decedent Armed Forces?		S. 13. \	Was Deceder f Yes, specify	nt of His y Cuban	panic Origin? (S , Mexican, Puer	pecify Yes or No.)	lo-	14. Race - Americ Black, White,	
7 (urs af	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 1 1 If Yes, Give Year or Dates:	40		1□Yes X	□No	Specify:			Specify White	e
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2 2	within ne. han *	mpje	Elementary/Secondary (0-12)	College (1-4or 5	i+)		Offic		iring most of wo	rkiig	D =		
	Hygie Hygie other i	ပိ	17. Father's Name (First, Middle, L.	ast)		Dank	01110		18. Mother's Nar	ne (First, Middl		nking	
2/12/0 254 Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natureli, or Items 23a or 28a-f show eny injury or other traumatic event, the Madical Examiner must be notified at once.	To Be	Stephen Haight					1	Nellie		-,	, camaino,	
_ , @	2 sho and ! is ma		19a. Informant's Name/Relationshi									or Town, State, Zip	Code)
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00 C 140 Ball	Pagini e a		1 / Frisk	Birlas	7				ım St.,				
			23a. Pari 1. Enter the disease, or c shock, or heart failure. List or	omplications that caused by one cause on each lin	the death	. Do not ente	or the mode o	of dying,	such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a Sepsis									Onset and Death
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4.0 2.0	Attending Physician: The law requires that the death certificate be executed rideath. Getor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4☐ Pregnant at 9☐ Unknown			Ectopic pregi Other (speci					Month	Day Year
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_	To the within To the comple	Me	29b. Signature and title of certifier				29c. Li	icense n	umber		29d. Date	e signed (Month, E	Day, Year)
			· Mus	MD			P	531	612		2/	13/06	
5	H 10		30. Name and address of person wh	o completed cause of de	ath (Item :	23a) (Type, P				14.0			
مک	Sta	0	31. Date filed (Month, Day, Year)	Daier 9 k	רב Y Signatu	rea 1-th	way &	br.	Berlin	, july	0181	1.1	
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			For State Registrar	State o	f Marylar	-	artmer ertificat				lental Hy	giene		05953	
Ø.	Physicia	an	1. Decedent's Name (First, Middle								2. Date of Do Month	eath Day	Year	3. Time of Death 19: 50 A M	
	/Medic	al	JOHN ROBERT 4a. Facility Name (If not institution)				4b Cin	Town or	Location of	of Death	Feb.	14 46 CO	2006 unty of Death		
	Examin	er	Atlantic General		mber)		Berl		Location	DI Deali		40.00	Word		
	Funeral	Ξ.		6. Sex 1 M 2 F	7. Age (In yrs.	last birthday) If Unde	r 1 Year	If Under		8. Date of Bi	rth		place (State or Foreign intry)	-
w/s	Director		219-07-0091	t*□M 2□F	8	9 Yrs.	Months	Days	Hours	Min.	Nov. 1	5, 191		yland	
	pus *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or L	ocation							10d. Inside City Limits	_
	Maryl	JO:	Maryland Worce	ster		erlin								1 ☐ Yes 2 ☑ No	
	r 28a	Funeral Director	10e. Street and Number			011111	10f. Zip	Code		_		10g. Citizen	of What Cou	intry?	_
	th with	ai D	105 Ennis Lane					2181	1			US	A		
	r dea	ıner	11. Marital Status	Armed Fo	edent Ever in U	.S. 13				igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	0- 14.	Race - Amer Black, White		_
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3altimore,	of He of He If Item or oth		20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation	3 □Removal from	State	Place of Disp cemetery, cri	ematory or o	other plac			Date		ion - City or T		
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Srd 2	v requires been sign should be										1 🗆	Yes 2 € N	lo 3∏Pro	bably 4 Unknown	
().6.6 7. Cr	as b	Completed									24a. Was	s an 2 opsy ormed2	4b. Were aut prior to o death?	opsy findings available ompletion of cause of	1
<u> </u>	. 42 0										1 ☐ Yes	2 No	1 Yes	2 1 No	-
V. V	Physician: this certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2] ER/Outpatis	ent 3⊡ D	Othe	00		h <i>Ch</i> eck o <i>nly</i> me 5 ☐ Res		Other (Case	(4.1)	
760	g Phy ier this	in:	27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time Injury		28c. Injun Worl		arsing ric	28d. Describe			, , , , , , , , , , , , , , , , , , ,	-
Sior - S	Attending r death. ector: After by the fune	atlo	1 Natural 5 Pending	ation	, Day 7 0a.7	нцагу	М		Yes 2	No					
Jacolos 219- Division	in the	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 289. Place	of Injury - At h ing, etc. (Speci		treet, factor	y, office				(Street and N wn, State)	umber or Rui	ral Route Number,	
// [Hospitel 24 hours a Funeral (29a. Certifier 1 Certifyin	g Physician To the	e best of my kin	JWladys, des	ith occurred	at the to	na. date av	id placa.	and due to the	causels) an	I manner as	slated.	-
	To the Hospitel or A within 24 hours after or To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical one)	Examiner: 🕼n the b	asis of examina ner stated.	ation and/or	nvestigation	n, in my o	pinion, dea	ath occur	red at the time	, date and pla	ice, and due	to the cause(s)	
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	, Sta		31. Date filed (Month, Day, Year)	\$32. F	Registrar's Sign	ature	et 3	, , ,	0	- ' '		/			
7 2	Registr	ar	FEB 2 8 2	006	المار ماليا	1	· Jan	,							

			1 - For State Registra MEND#25, 27, 2	State o	f Mandan	d / Don	artment of H	lealth and Me	ental Hyg	2006	05954
	W- I -		1. Decedent's Name (First, Middle,		2/10/00,11	111/1/11/00/2	tinoato or		2. Date of Deat	og. 110.	3. Time of Death
	Physici	an	_		-				Month	Day Year	Hina Lu
	/Medi		Laura 4a. Fecility Name (If not institution, c	Ann	Juenen	nann	the City Tours of	r Location of Death	FEB	07 200 4c. County of De	-
	Examir	ier			·		4b. City, Town, C	Location of Death			am
100			Western Maryland Ho 5. Social Security Number 6	spital Cen	ter 7. Age (In yrs. i	last hirthdayl	Hagerstown		8. Date of Birth	Washington	irthologo (State or Feering
45	Funeral Director		,	1 ☐ M 2 🖾 F	35	Yrs.	Months Days	Hours Min.	(Month, Day,	Year) 9. 6	inthplace (State or Foreign Country)
			217-04-0882 Usual Residence of Decedent		33				Sept. 7,	, 1970 Ma	ryland
	/lanc		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	Man Hed	tor	Maryland Montgo	no rv	1	Rockvi	110				1X Yes 2 No
	death with the Maryland me 23s or 28s-f show	Director	10e. Street and Number	поту		COCKVI	10f. Zip Code		1	0g. Citizen of What 0	Country?
	3a o		5816 Wainwright	A3707110			20	851		USA	
	death	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (Spec	cify Yes or No-	14. Race - Arr	nerican Indian,
(0	r Iter	Fur	1 Never Married 2 Married	Armed Fo	2 👿 No		If Yes, specify Cuba	an, Mexican, Puerto F	Rican, etc.)	Black, Wh	ite, etc.
8	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	ve ates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	hite
21215-0036	72 hours after natural', or Ite	Completed	15. Decedent's	Education		16a. Dece	dent's Usual Occup	ation		16b. Kind of Busines	
2	within 7 ene. than "r	ple	(Specify only highest of Elementary/Secondary (0-12)	College (1	1-4or 5+)	life.	NOT use retired	during most of workin d)	g		
21	d wit	DO.	8				None			N/A	
P	otho vent	Be	17. Father's Name (First, Middle, La	st)				18. Mother's Name	(First, Middle, M	Maiden Sumame)	
Maryland	12 should be filed within hand Mental Hygiene. 7 is marked other than "rearmatic event, Ira Max	ToE	Pau1	G. Ju	enemann				Doreen	F.	Co1e
ary	shore and A ama		19a. Informant's Name/Relationship				ng Address (Street	and Number or Rural	Route Number		
Σ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow amy jury praither traumatic event, II a Modical Exercities in at the notified an ance.		Paul G. Jueneman	n/Father		5816	Wainwrigh	it Avenue,	Rockvi	lle. Marvl	and 20851
Baltimore,	tem Hem		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of matory or other place	Da		20c. Location - City of	
E	a su su su su su su su su su su su su su		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State		s Cemeter		2006	Rockville,	Maryland
Ħ	ortan		21 Signature of Funeral Service Lic		10			ss of Facility DeVe			Maryland
B	Dep Imp		Musel	111 200	l. Vice	100		er Park Dr			MD 20877
	e 7:18 36		23a. Part1. Enter the disease, or co	mplications that o	aused the death						Approximate
			shock, or heart failure. List on Immediate Cause (Final	v one cause on e	ach line.		•	-			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. BONE	LOBSTRU	CTIONS	SECONDARY	TO CECAL DIVIE	- VOLVI	ILUS	6 DA4S
	Examiner			Due to	(or as a consequ	ience of):	OHO	- CUI			
1 2		_	Sequentially list conditions,	b. — Due to	or as a consequ	ence of it	Di	DM			
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			000	1-2				
	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	хаг	that initiated events resulting in death) Last	c. Die to	or as a consequ	rence et):	0 6				
760,	be e ician buria	calE		20	l)	0					
687	phys the	dic	`	d							
9 ×	leath certificate b attending physic I for use as the b	Physician/Medi	IF FEMALE:	220 If you out	come of program	201					
Вох	ath o	lan	23b. Was decedent pregnant in the past 12 months?	1☐Live b	come of pregnai irth 2□Fetal	death 3	Ectopic pregnancy	,		23d. Date of de Month	elivery Day Year
0	the a	/slc	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Pregn 9☐Unkno	ant at time of de own	eath 5∟	Other (specify)	-			54, · · · · ·
Ф.	that the de ed by the a detached	Ph		contribution to de		Min = 1 = 4 = 1	-4-4-2		On Didas		
Ś	ires tha signed d be det	Completed by	Part II. Other significant conditions			liting in the ui	nderlying cause giv	en in Part I.			to the cause of death?
50	w requir been si should	ted	PERSISTENT VEGE	TATIVE S	1112				1 Ye	s 2 7⊠ No 3∏F	Probably 4 Unknown
e Č	as b	ple	CLOSED MEAD IT	JURY S	GCONDAK	24 TO	MUA		24a. Was ar		utopsy findings available completion of cause of
H	The ate h page	Ö							perform	ned? death?	
of Vital Records,	Physician: rthis certifica ral director, i	0	25. Was case referred to medical					26. Place of Death			
/	yeic is ca direc	To B	examiner? 1∰ Yes - 2∰ No -	Hospital: 1 🗆 I	npatient 2 🗆 8	R/Outpatien	t 3 DOA Oth			nce 6 Other (Sp.	ecify)
	9 Pt ter th neral		27. Manner of Death	28a. Date of	of Injury th, Day Year)	28b. Time of Injury	28c. Injun Worl			w injury occurred	7.
Division	Attending ir death. ector: After by the funer	atlo	2√ Accident 5 Pending investigation			3:00r		Yes 2 Mo P	edestrian	struck by a	euto
<u>S</u>	I or Attendi efter death. Director: A I in by the fu	을	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place	of Injury - At ho	me, farm, str	eet, factory, office	28	Bf. Location (Sti	reet and Number or F	Rural Route Number,
Ö	al or	Certification:	4 El Hornicido	Dundi	ng, etc. (<i>Specity</i> Shreet			171	City or Town	, State) Cwn Rd: Beth	oma MD
	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying I	hysician: To the	best of my know	vledge, death	occurred at the tin	ne date and place ar	nd due to the ca	use(s) and manner a	is stated
	P Hc	edical	(Check only 2 Medical Expone)	iminer: On the ba	asis of examinati ner stated.	ion and/or inv	estigation, in my o	pinion, death occurred	d at the time, da	ite and place, and du	e to the cause(s)
	To th Mithir To th Yomp	Me	29b. Signature and title of certifier				29c. License	e number	25	d. Date signed (Mon	ith, Day, Year)
	2		> mmul	MI)		5000	2895	7	= BRUARY	01 2001
	4	-	30. Name and address of person wh	completed cause	e of death (Item	23a) /Tune				= UNUMEY	,01,2006
		İ	PAULING DACEY	. sompleted tads	o or obatti (itelli	_ua/ (+ype,	1500 16	ennsylvania A			
	Sta	te	31. Date filed (Month, Day, Year)	32.	egistrar's Signat	nie 🔻	4	own, MD 2174	12		
	710	ar	EER 10	2000	Same I	H M	actis				

			For State (1 - State Registrar	of Maryland / Departr <i>Certifi</i>	ment of Health and icate of Death	Mental Hygien	CCECH duu:
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month D	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and no	imber) 4h	. City, Town, or Location of Deat	h 02	1. O() 1750 M
	Examir	er	COASTA HOSAGE A	-THE LAKE	SALISRUR-		Wicomico
	Funeral		5. Social Security Number 6. Sex	O -	Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthplace (State or Foreign
**************************************	Director		220-28-2/18 10M 20AF	15 Yrs.	Julio Bayo House	7-24-31	o Md
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	on		10d. Inside City Limits
	Mary	tor	md Somercet	Princess	anno		1 tryes 2 □ No
	th the	Director	10e. Street and Number		Of. Zip Code	10g. C	Citizen of What Country?
	death with the Maryland oma 23a or 28a-f ehow if must be notified at		29564 Degl Islan	d Koad	21853		U.S.A.
	items items	Funerai	11. Marital Status 1 Never Married 2 Marned 1 Never Married 2 Marned	edent Ever in U.S. 13. Was free?	Decedent of Hispanic Origin? (S s, specify Cuban, Mexican, Puen	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
920	hours after tural', or ite al Examina	þ	3 Widowed 4 Divorced Year or I	2 No ive 1 \(\text{1} \) ates:	Yes 2 No Specify:		Specify: Black
21215-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed	16a. Decedent's	s Usual Occupation of work done during most of wo.	rking 16b.	Kind of Business/Industry
121	within ene. than "	mpi		1-4or 5+)	VOT use retired)	L D-	1 0. (1
	filed whygie Hygie other there		17. Father's Name (First, Middle, Last)	Trouv	16-10 N W OF	me (First, Middle, Maide	en Sumame)
Maryland	lental ked c	To Be	Moody Jones		Flore	NG= 11)	1:+
lary	2 should and M le marl		19a. Informant's Nam Pelationship (Type, Print)	19b. Mailing Ac	idress (Street and Number or Re		or Town, State, Zip Code)
-	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene the Health, or Itema 23a or 28a-f ehow tem 27 ie marked other than "natural", or Itema 23a or 28a-f ehow other traumatic event. The Medical Exercities must be notified at		Julia Garrison	daughter 7409 F	Barton Hus.	alishury,	md. 21801
Baltimore	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1	State 20b. Place of Disposition cemetery, cremator	y or other place)	0	Location - City or Town, State
ij			4 □ Donation 5 □ Other (Specify) 21. Signature of Americal Service Licensee	1 Fivity (ressame md,
Ba	permit. Departr Importu		fund tok	0.0	Ban 371 D	CONOK.	1.th Funeral Home
*			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not enter the	e mode of dying, such as cardia		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ISCHEMIC	BOWEL	_	Onset and Death
	/Medical Examiner		resulting in death) Due to	(or as a consequence of):		CILE	
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	(or as a consequence of):	H MAL	Cill-	,
	outed id ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	PREUMON	J.A.		
Ö,	ate be executed hysician and the burial-transit	I Ex		(or as a consequence of):			
8760,	cate b physic the b	dical	d				
9 xc	ding iding ise as	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, ou	tcome of pregnancy			23d. Date of delivery
Box	atte atte for	iclar	in the past 12 months? 1 ☐ Yes 2 No. 4 ☐ Preg	nant at time of death 5 🗌 Oth	opic pregnancy er (specify)		Month Day Year
P.0	that the de ed by the detached	by Physician/Med	9 □ Unknown 9□ Unkr				
ds,	S F 9		Part II. Other significant conditions contributing to o	eath but not resulting in the underl	ying cause given in Part I.		o use contribute to the cause of death? 2. No 3 □ Probably 4 □Unknown
of Vital Record	> 10 %	Completed		×			
Re	e la has je 2	duc				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ta	ician: Th certificate rector, pag	ø	25. Was case referred to medical		26. Place of Dea	1 ☐ Yes 2 ☐ N ath (Check only one)	No 1 Yes 2 No
	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No Hospital:	Inpatient 2 ER/Outpatient 3	Other	lome 5 Residence	6 ☐ Other (Specify)
o u	ding P		Directoral O I origing	th, Day Year) Injury	28c. Injury at Work?	28d. Describe how inj	ury occurred
Division	Attending r death. sctor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	of Injury - At home, farm, street, f		28f Location (Street	and Number or Rural Route Number,
=	al or A s after I Dire	Certification:	4 Homicide determined build	ing, etc. (Specify)	actory, office	City or Town, Sta	te)
	To the Hospital or Attending Physician: within 24 hours after deals To the Funeral Director. After this certific completely filled in by the funeral director,	edical C	29a. Certifier 1 Certifying Physician: To th	e best of my knowledge, death occ easis of examination and/or investig	urred at the time, date and place	and due to the cause((s) and manner as stated.
	To the H within 24 To the F complete	Medi	one) and mar	ner stated.			
l	No To	-	23b. Signature and little of certified	ALAS - KT	29c. License number		Date signed (Month, Day, Year)
1	mt		30. Name any a ress of person who completed cau	se of death (Item 23a) (Type. Print	(000 Th	HOTTINE	
-)		30. Name and a ress of person who completed cau	ACS DEE	RSHEAD S	t215130,29	10812 DM
	Sta Registr			Registrar's Signature	P.		

State of Maryland / Department of Health and Mental Hygiene

CARP, MARTIN

2/10/6

1233 PM

			1 - For State Registrar	State of M	Marylan	d / Depa	artmer	t of H			ental Hyg)5957	
	n n		1. Decedent's Name (First, Middle	, Last)						2	2. Date of Dea Month	th Day		ear	3. Time of Death	
	Physici /Medic		Donald Milton	Kuehl							Februa				4 00 P	М
	Examir	er	4a. Facility Name (If not institution,	give street and number	er)		4b. City,	Town, or	Location of	Death		4c.	County of	Death		
1, ,	Alagar e.	. F	Frederick Memo					rede		4 Mag		_	ederi			
	Funeral Director		5. Social Security Number 485-26-7908 Usual Residence of Decedent	6. Sex 1 ☑ M 2 ☐ F	Age (In yrs. I	Yrs.	Months	Days	If Under 24 Hours	Min.	B. Date of Birth (Month, Day April 15	Year)		Birthpl Count Iowa		g n
	land w		10a. State 10b. County		10c. City	y, Town or Lo	cation							10	d. Inside City Limit	ls
	Mary -1 sh	ō	Maryland Frede	erick	F	Freder	ick								1 ☐ Yes 2 📉 N	io
	r 288	ec	10e. Street and Number					Code			1	0g. Citi	zen of Wh	at Count	ry?	
	h with	Funeral Director	7938 Yellow Spri	ings Road			21	702				Ur	nited	Sta	tes	
	deat	ner	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.	S. 13.	Vas Dece	dent of Hi	spanic Origi	n? (Spec	rfy Yes or No- ican, etc.)		14. Race -			_
9	or Ite	E.	1 ☐ Never Married 2XX Marrie		³ N°051-	_			Specify:	rueno ni	ican, etc.)		Specify:	White, e		
8	ural',	d b	3 Widowed 4 Divorced	Year or Dates	19	955							зреспу.	WIIT		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show ta Masical Examiner must be notified at	lete	15. Decedent' (Specify only highes	s Education t grade completed)		16a. Deced	kind of wo	rk done d	furing most o	of working	7	16b. Ki	nd of Busir	ness/Ind	ustry	
12	withir ane. than	E C	Elementary/Secondary (0-12)	College (1-4o	r 5+)		DO NOT u		,			۸ -		.		
9	Hygi Hygi ther ant,	Be Completed by	17. Father's Name (First, Middle, L			Comp	LIULI	EL	18. Mother's	s Name (First, Middle, i		Sumame)	LTIIE		
an	d be ental ked c	To B	Fred Kuehl								ngeman		- ,			
2	mari mari	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	ng Address	(Street a			Route Number		Town, Sta	ate, Zip	Code)	
Baltimore, Maryland	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural; or Items 23s or 28s-1 show eny injury or other traumatic event, it is Medical Extending must be notified at Once.		Coralinn Kuehl /	Wife		7938	Yello	w Sp	rings	Rd.	Freder	ick,	MD	2170	2	
ğ.	of Hear		20a. Method of Disposition		20b. P	lace of Dispo emetery, cren	sition (Nai	ne of	e) Fe	brua	ry 15,	20c. Lo	cation - Ci	y or To	vn, State	
Ē	Page nent c		1 ☐ Burial 2 S Cremation 4 ☐ Donation 5 ☐ Other (Sp			thaven				200	1.00	rede	erick	, Ma	ryland	
at	permit. Departr Importu eny Inji		21. Signature of Fundral Service L	icensee		R 6	. Name ar	nd Addres	s of Facility	al Se	rvices					
_	40 E 9 9		23a. Part1 Enter the cuesase, shock, or beart allure. Ust o			9.	$501 \mathrm{C}$	atoc	tin Mt	n. H	lwy. Fr	eder				
10000000000000000000000000000000000000	Physician /Medical Examiner sthe pnual-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. VENT Due to (or a b. CARA Due to (or a	As a consequence of a c	uence of):	TO	CH'	CALUC	>1/4					Interval Between Onset and Death	
P.O. Box 68	Physician: The law requires that the death certiticate be executed this certiticate has been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal at time of de	death 3	Ectopic pi Other (sp			7		2	3d. Dale o		y Day Year	
rds, F	quires tha an signed uld be de	ed by P	Part II. Other significant condition			-	nderlying o	ause give	n in Part I.		23e. Did tot	-			e cause of death? bly 4 \(\sum \)Unknow	'n
Division of Vital Records,	The law re ate has bee bage 2 sho	Completed	COPD							_	24a. Was a autops perform	y ned?	prio	r to com	sy findings available pletion of cause of	le
ā	striffic etor,	Be (25. Was case referred to medical examiner?	14					26. Place o	f Death [Check only on					
n of V	To the Hospitel or Attending Physician: The law within 24 hours atter death. To the Funerel Director: Atter this certilicate has completely tilled in by the funeral director, page 2.	2	1 ☐ Yes 22 No 27. Manner of Death 12 Natural 5 ☐ Pending	Hospital: 1 Inpa 28a. Date of In (Month, D		R/Outpatien 28b. Time of Injury	2	8c. Injury Work	at ?	28	5 Reside			Specify,		
S	tor: /	cat	2 Accident investiga 3 Suicide 6 Could no	ot be			М		′es 2 □ No							
N N	urs atter or rel Direction	Certification:	4 Homicide determin	ned 286. Place of I building,	etc. (Specify	·) 					City or Towr	n, State)			Route Number,	
	the Hosp nin 24 hou the Fune npletely ti	fedical	one)	Physician: To the bes xaminer: On the basis and manner:	of examinati	wledge, death ion and/or inv	estigation	, in my op	inion, death	place, and occurred	at the time, da	ate and	place, and	due to	the cause(s)	
	To To	Σ	29b. Signature and title of certifier					. License			2	_	signed (A			
7			1/1/	-		ハロ		>00	0604	69		F	eb	14	2006	
5	HVH		30. Name and address of person w					177.		.1 34	D 0170	1				
	Sta Registr	te ar	Jeremy R. Yospin 31. Date filed (Month Day, Year)	2006 32. egis	trar's Signat				eaeric	к, М	ע 21/0	T				

DHMH 17 Rev 1/2001

		1	For State Registrar	State of	Marylan		artment of rtificate of		d Mental Hy	ygiene Reg. No.	006	05958
	/siciar	13	1. Decedent's Name (First, Middle, La TOHN KISSI			**			2. Date of D Month FEBRU	eath Day	5 2006	3. Time of Death
	ledica amine	*	4a. Facility Name (If not institution, given MONTGOMEN 6.5. Social Security Number 6.5.	e street and numb			OLNE	r If Under 24	Death Hrs. 8. Date of B	irth 4c.	ONTGO	
Direc	ctor		578-14-8613 Usual Residence of Decedent	⊠ M 2□F	86	Yrs.	Months Days	s Hours M	9/15	ay, Year)	Cou	trict of
with the Maryla a or 28a-f show	De notified at		Md. Montgom 10e. Street and Number 12018 Milton St	_		y, Town or Lo leaton		12		10g. Citiz	zen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 🔀 No intry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-7 show	Examiner must be notified	D L C	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? No			Hispanic Origin ban, Mexican, P	? (Specify Yes or N uerto Rican, etc.)	0- 1	14. Race - Amer Black, White Specify: Wh	. etc.
Maryland 21215-0036 nd 2 should be illed within 72 hours all the and Mental Hygiene. 27 is marked other than "natural", or	nt, Ir.e Medical I		15. Decedent's E. (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last,	College (1-4	lor 5+)	(Give	dent's Usual Occi kind of work don DO NOT use retir Consul	e during most of ed) tant		Go	vernme	,
ylanc could be fi Mental I warked of	To Bo	וֹ בֿ	Gurney Jay K	issinge	er			Minn		Eige	el	
e, Mar 1 and 2 sh 4ealth and 9m 27 1s m	ger traum		19a. Informant's Name/Relationship (Temur Alimi/ f 20a. Method of Disposition	* .	20h P	3707			Olney,	Md.	20832	
Baltimore, permit. Pages 1 a Department of Hea mportant: If Hem	Call		Metriod of Disposition Metriod of Disposition Service 1	y)	ate Ga	ate of	Heave	1	10/06 Universa	Sil	_	ring, Md.
Deg de	any a	1	1/201/	not	064	41	1 Kenn	edy St	., N.W.	Wash		Approximate
S8760, (cate be executed Examily Physician and	cal ner		23a. Part1. Enter the disease, or com shock, or heart fature. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequ	uence of): UAL uence of):	Falul					Interval Batween Onset and Death C WEEK
Box 6 eath certif	detached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		h 2 ☐ Fetal nt at time of de	death 3	Ectopic pregnan	су		2	3d. Date of deliv	rery Day Year
cords, P. v requires that the been signed by	2	1	Part II. Other significant conditions of	_			nderlying cause g				se contribute to	the cause of death?
al Reconstitution The law of ficate has be									24a. Was auto perf 1 Yes		24b. Were aut prior to co death? 1 \sum Yes	opsy findings available ompletion of cause of
Division of Vital Records, P.O. or Attending Physician: The law requires that the dafter death. Director: After this certificate has been signed by the	ation. To Re		25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of (Month,		ER/Outpatien 28b. Time of Injury	28c. Inju	ther: 4 \(\text{Nursir}	Death (Check only ng Home 5 Res 28d. Describe	idence 6		fy)
Division or To the Hospital or Attending Phymbin 24 hours after death. To the Funeral Director: After the Hospital or the Funeral Director: After the Hospital Original Original Phymbia or 10 the Theorem 10 the Theorem 10 the Theorem 10 the Theorem 10 the Theorem 10 the Theorem 10 the Theorem 10 the Theorem 10 the Theorem 10 the Theorem 10 the The	Gertification.		3 Suicide 6 Could not be determined	28e. Place of	Injury - At ho , etc. (Specify	ome, farm, str	eet, factory, office)		(Street and own, State)		al Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir	pretery m		29a. Certifier 12 ← Certifying Ph (Check only one) 2 ← Medical Exam	niner: On the bas and manne	is of examinal	wledge, death tion and/or in	occurred at the restigation, in my	time, date and pl opi <i>n</i> ion, death o	lace, and due to the occurred at the time	cause(s) and	and manner as place, and due	stated. o the cause(s)
To the within To the	200		29b. Signature and title of certifier	OSPITALIS	T			se number			signed (Month,	
-			30. Name and address of person who SONW HOLMEL, I	1.D. 18101	PRING	E PHILL	P DRIVE,	DLNEY	MARILAN			
Reç	State gistrar		31. Date filed (Month, Day, Year) FEB 1 0 2	006 32. Reg	istrar's Signa	ture Ap	arti					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day 18, LaBEFF 2006 3:44 PM JOHN THOMAS February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Somerset Crisfield McCready Memorial Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 7, 1930 Birthplace (State or Foreign Country)
 New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Yrs. Director 75 133-20-4774 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Marion Station Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21838 4745 Green Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1⊠Yes 2□No Korean IfYes, Give Year or Dates: War 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No δ Specify: 3 Widowed 4 Divorced and Mental Hygiene. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electric Electrician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importaent: if Item 27 is marked oth any injury or other treumatic event 900g. Be Catherine Parshaw Walter LaBeff 19a, Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4745 Green Road - Marion Station, Maryland 21838 Joan LaBeff (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 2/22/06 Salisbury, Maryland isbury Crematory 21. Signature of Funeral Service Licensee

May Both Bradshaw-Pruitt 22. Name and Address of Facility Bradshaw & Sons Funeral Home 22. Name and Address of Pacing

Pary Beth Bradshaw—Pruitt

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 306 W. Main Street - Crisfield, Maryland 21817 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** therosclero /Medical Due to (or as a consequence of): **Examiner** ongestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit 1 Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicials for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 28 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 3 DOA ဥ 1 Yes 1 Inpatient After this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident Director: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 M.W. 2006 6Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 VVICC 150 bent MID. 32. Registrar's Signature 31. Date filed (Month, Day, Yeer) State Registrar 2005

DHMH 17 Rev 1/2001

Mark Al 06-0129 crn		.be	Unpend item#23a,27,p	ype or Prin en E, g553 State of Ma	t in Bla 3/2/06 irvland	ack Inc	lelible In	k. Ensure Health and	All Copies	s Are vaien	Legible.	00000
CLII			1 - For State Registrar		, ,		tificate o			Reg. N	4000	U 9 7 9 U
	Physicia	an	1. Decedent's Name (First, Middle, Last)						2. Date of D Month	eath Di	ay Year	3. Time of Death
	/Medic	al		len	Lab	er			Februa	ary :	20, 2006	7:13 P M
	Examin	er	4a. Facility Name (If not institution, give s 521 Winifred Road	street and number)				, or Location of Dea erland	ath	4	c. County of Deat Allegan	
*20	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. las	t birthday)	If Under 1 Year Months Day	ar II Under 24 Hr		irth	9. Birt	place (State or Foreign
61	Director		213-76-7733 1x Usual Residence of Decedent	M 2□F 4	9	Yrs.		110010	Mar 5	,195	56	MD
Maryland	a-f ehow	tor	10a. State 10b. County MD Allegan	y		Cumb	erland		-			10d. Inside City Limits 1 ✓ Yes 2 ☐ No
de Aix Aix Aix	or iteme 23a or 28a-f ehor	rai Director	10e. Street and Number 521 Winifred Road				10f. Zip Code	21502			itizen of What Co USA	untry?
laryland 21215-0036	al', or iteme	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4X Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:			as Decedent of Yes, specify Cu	f Hispanic Origin? (uban, Mexican, Pue lo <i>Specify:</i>	(Specify Yes or N orto Rican, etc.)	lo-	14. Race - Ame Black, White Specify: Wh	e, etc.
Maryland 21215-0036	iene. r than "natur the Medical i	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5-	+)	(Give k life. D	O NOT use reti	ne during most of wi red)	orking		Kind of Business/	ndustry
, L	al Hygiene. I other than		12 17. Father's Name (First, Middle, Last)	·	5	ewag	e Depar		ame (First, Middle		of Cuml	periand
ylano ould be	Mental Marked o	To Be	L. Paul Laber					JoAnn	E. (Wig	ger)	Laber	
≥ 5	n 27	2 0	19a. Informant's Name/Relationship (Ty) Gary Laber	brothe	er	1470	6 МсМи	et and Number or F ullen Hwy.	Cres	apto	or Town, State, Z WN M	D 21505
Baltimore,	nent of H int: If ital		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	cem	etery, crem	ition (Name of atory or other p norial Par		Date 2/25/2006	211	ocation - City or umberlan	
Balti	Department of important: If any injury or once.		21. Signature of Funeral Service License	hell	U'	22.		ellî Funeral I Irginia Aven		erland	L MD 2150	2
No.			23a. Part Enter the disease, or compli- shock, or heart failure. List only on	cations that caused e cause on each line	the death.	Do not ente					1, 1110 2 100	Approximate Interval Between
	hysician /Medical		Immediate Čause (Final disease or condition resulting in death)	Hypertension Due to (or as a			rotic Car	diovascular	Disease			Onset and Death
	xaminer	Jer	S uentially list conditions if any, leading to immediate	טעפ זס (or as a	consequen	ice of):						
), executed	n and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequen	ice of):						
6876(physicie is the bur	edicai	d									
Division of Vital Records, P.O. Box 68760, ospitel or Attending Physician: The law requires that the death certificate be executed	been signed by the ettending physicien an should be detached for use as the burial-tr	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal de	ath 3 🗆 E	Ectopic pregnan Other (specify)	псу			23d. Date of deliment	very Day Year
rds, P.	n signed by	d by Ph	Part II. Dther significant conditions con	tributing to death bu	t not resultir	ng in the und	derlying cause o	given in Part I.			use contribute to	the cause of death?
ecol	as bee	Completed							24a. Was	psy	prior to c	opsy findings available
E 18	cate has		(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)						1 Yes	ormed? 2□ No	death?	2□ No
Vita	is certificate director, pag	9 Be	25. Was case referred to medical examiner? 1 △ Yes 2 ☐ No	ospital:		10	45 BOA C		eath Check only		Y	at scene
P O	er this	n: To	27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury (Month, Day		b. Time of	28c. Inj	4 Nursing	Home 5 ☐ Res 28d. Describe		6 白Other (Spec ary occurred	ify) at SCCIE
oigin andin	death. ctor: After y the funer	atio	1 Matural 5 Pending 2 Accident investigation	(Month, Day	1941/	Injury		□Yes 2□No				
Divis	s after de la Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc.	y - At home (Specify)	, farm, stree	et, lactory, office	е	281. Location City or To	(Street a wn, Stat	nd Number or Rui e)	ral Route Number,
the Hospii	4 1 0	Medical	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of er: On the basis of and manner stat	examination	dge, death and/or inve	occurred at the estigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time	cause(s date an	and manner as d place, and due	stated. to the cause(s)
T _o	within 2 To the complet	Σ	29b. Signature and title of certifier	1000		Λ		nse number			ate signed (Month	
			30. Name and address of person who could be seen and address of person who could be seen and the	Talla mpleted cause of de	ath (Jtem 23	Maj (Type, P		D.C.M.E.			uary 21,	
_					0			reet, Balt	timore,	Mary	Tand 212	.01
	Stat Registra		31. Date filed (Month, Day, Year) FEB 2 8 2006	32. Registra	's Signature	Good						

			For State Registrar	State of M	Marylan		artment of I		ind Menta		ene . No. 0 0 6	059	161
퍉		k.	1. Decedent's Name (First, Middle	, Last)						te of Death	Day Ye	3. Time	of Death
	Physici /Medic	al	TESSIE SILVER						FEB	RUARY	7, 2006	3:50) A ^M
	Examin		4a. Facility Name (If not institution,				4b. City, Town,		f Death		4c. County of I		
			MONTGOMERY GE		ITAL Age (In yrs. I	last hirthday	If Under 1 Year	LNEY	24 Hrs. 8 Da	te of Birth	9	TGOMERY Birthplace (State	or Foreign
	Funeral Director		5. Social Security Number 578-62-1055	1 M 2 XF	99	Yrs.	Months Days		Min, (M	onth, Day, Y	rear)	Country)	
. 5.			Usual Residence of Decedent							10, 1			
	how	_	10a. State 10b. County	OMEDN	10c. City	y, Town or Lo		R SPRIN	IC.			10d. Inside	City Limits es 2 ☐ No
	r 28a-f ehow	cto	MARYLAND MONTG					C DI KII	···	10-	035		
	with the	Funeral Director	10e. Street and Number	VIII #04			10f. Zip Code	20906	1	100	. Citizen of Wha	•	
	eath	erai	15121 GLADE DRI	12. Was Decede	nt Ever in U.	S. 13.	Was Decedent of If Yes, specify Cul			es or No-	14. Race -	American Indian	
30	within 72 hours after death with the Maryland liene. Triem natural, or teme 23s or 28s-1 show Irie Macinal Examination nations.	by Fun	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	X No		lf Yes, specify Cul 1 □ Yes 2ሺ No		, Puerto Rican,	etc.)	Specify:	White, etc. WHITE	
5-0036	72 hou		15. Decedent	's Education		16a. Dece	dent's Usual Occu	ipation	of working	16	6b. Kind of Busir	ness/Industry	
בות	within 7. ene. then "n	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-40	or 5+)	lite.	kind of work done DO NOT use retire	ed)	of working				
7	filed within Hygiene.	S		4			TEACHER				ELEMENTA	ARY	
	d a b	o Be	17. Father's Name (First, Middle, MORRIS SILVERMA					18. Mother			CHASEN		
	and 2 should ealth and Men n 27 le marke er traumatic		19a. Informant's Name/Relations BARBARBA TALAMO				ng Address (Stree CONCORD I				City or Town, Sta 02493	ate, Zip Code)	
ē,	of Hea		20a. Method of Disposition		l c	lace of Dispo	sition (Name of matory or other pl	ace)	Date	20	c. Location - Ci	ty or Town, State	
Ë	Pages ant: If it		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)				LOM CONG		EB 9, 2	006 CA	APITOL F	HEIGHTS,	MD
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 le marke eny injury or other traumatic once.		21. Si natura of un	Licensee		DA 1	Name and Addi ANZANSKY- L70 ROCK	ress of Facility -GOLDBI VILLE I	y ERG MEM PIKE, R	ORIAL OCKVII	CHAPELS	S, INC. RYLAND	20852
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	sed the death							Approxir Interval	Between
	Physician		Immediate Cause (Final disease or condition	OBS	7 200	TZV	6 601	VG D	ISEA.	s É		Onset ar	
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):							
· ·	Examine	Ļ	Sequentially list conditions,	b. Dues to fee	as a consec	- He energy							
	nsit	niner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury	000 10 (0)	de a concect	GGIRIO OIY.							
	al-trai	Examin	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):							
8760	cate be executed bhysician and the burial-transit	dicai		d									
9	tificat ng ph) as th	ledi											
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths?	23c. If yes, outcom	me of pregna 1 2 ☐ Feta		⊒Ectopic pregnan	су			23d. Date of Month		Year
O.	the all	sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnan 9□Unknow		eath 5[Other (specify)					/	
0.0	res that the de signed by the a be detached f		Part II. Other significant condition	ns contributing to deat	h but not res	ulting in the u	inderlying cause g	iven in Part I.	. 2	3e. Did toba	cco use contrib	ute to the cause	of death?
Records,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	d by								1 ☐ Yes	2 □ No 3	Probably 4	⊕ onknown
CO	w require been si should l	Completed							2	4a. Was an	24b. We	re autopsy findin	gs available
Re	The lav	omp								autopsy performe	ed? dea	or to completion of th? Yes 2 No	of cause of
		a l	25. Was case referred to medical					26. Place	of Death (Che			7100 2010	
>	d d	To B	examiner? 1 🔲 Yes 2 👺 No	Hospital: 1 🗹 Inp	atient 2 🗆	ER/Outpatie	nt 3□ DOA	ther: 4 Nu	rsing Home	5 🗌 Residen	ice 6 □Other	(Specify)	
0	tending Ph leath. tor: After th the funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pendin	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	f 28c. Inj				v injury occurred		
Sio	Attending in death.	cati	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could	gation				☐Yes 2☐/		(Char		an Oural Cauta to	
Division of	affe Display	ertification:	4 Homicide determ	ined 286. Place of	etc. (Specif	ome, rarm, st	reet, factory, office	9		ity or Town,		or Rural Route ∧	umber,
_	To the Hospital within 24 hours and to the Funeral completely filled	edical C		ng Physician: To the be Examiner: On the basi									e(s)
	the H hin 24 the F nplete		one)	and manner									
	Son Con	Σ	29b. Signature and title of certifie					nse number				Month, Day, Yea , 7, 2 C	
0	25		Dush J. n		of do sale /la	n 03c) /T -		0.00			-535		
			30. Name and address of person FRANK 5. MAYO.	MD 16220	FRED I	ERZEK	READ Su	11 413,	GAZTH	ERIBU	RE, MA	RULAND -	20871
	St	ate	31. Date filed (Month, Day, Year)										
	Regist	rar	FEB 13	2006	10 LD	· ACTOR							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	arylan				ealth a Death			giene Reg. No.	2000	5 059	962
	Division		1. Decedent's Name (First, Middle, La	st)							2. Date of Dea		, Va	3. Time	of Death
	Physici /Medio		Grace Frances Lo	owe							Month 2	12^{Day}	200	8:35	Ам
1	Examir		4a. Facility Name (If not institution, given	e street and number)			4b. City,	Town, or	Location of	of Death		4c.	County of E	Peath	
			119 112th St., Ap	ot. C				an Ci	-			Wo	rcest	er	
	Funeral		Social Security Number 6. S	Gex 7. Ag 1 □ M 2 □ XF	ge (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h v. Year)	9.	Birthplace (State Country)	or Foreign
4	Director		5/9-0/-3034	2001	87	Yrs.					6/17/1	918		shington	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y. Town or Lo	cation							10d. Inside (City Limits
	Aaryl • • ho	5	MD Worce	ester	0.0	cean Ci	+ = 7								s 2 No
	the t	Director	10e. Street and Number	sster	00	Lean CI	10f. Zip	Code				10a Citi	zen of Whal	Country?	
	with a s	Ö	119 112th St., Apt	- C				842				rog. Oili	USA	Country:	
	hours after deeth with the Maryland urel', or Iteme 23s or 28s-1 ehow at Examinar mual be rictified at	Funerai	11. Marital Status	12. Was Decedent	Ever in U.	.S. 13. V			spanic Ori	gin? (Spe	cify Yes or No-	. —		American Indian,	
_	ther o	들	1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2 🛣	•		f Yes, spe	cify Cuba	n, Mexicar	, Puerto I	Rican, etc.)			Vhite, etc.	
3	urs a	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I ☐ Yes	2 € No	Specify:				Specify:	White	
21215-0036	2 ho	Completed	15. Decedent's E	ducation		16a. Deced	lent's Usu	al Occupa	ation	. ,		16b. Ki	nd of Busine	ess/Industry	
<u> </u>	Pin 7	ğ	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or:	5+)	life. L	DO NOT u	nk done d se retired,	luring mos)	t of workii	ng				
N	filed within 72 h Hygiene. other than "natuent, the Medica	5	12			Opera	tor					Γ	eleph	one Comp	any
and	o a ≥	Be (17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)		
<u>a</u>	Ment Ment arked	2	Francis Joseph 1	McDermott					S	ophi	a Deck				
Mar	es 1 and 2 should be fi of Health and Mental F i item 27 ie merked ot r other traumatic eve		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address	(Street a	and Numbe	er or Rura	l Route Numbe	r, City o	r Town, Stat	re, Zip Code)	
e e	and ealth n 27		Elizabeth Litz						., Ap	t. C	, Ocean	Cit	y, MD	21842	
9	of H		20a. Method of Disposition 1⊠Burial 2 ☐ Cremation 3 ☐	Demoval from State		lace of Dispo	sition (Nar	ne of ther place	9)	D	ate	20c. Lo	cation - City	or Town, State	
Ĕ	Pag ment ant: i		4 Donation 5 Other (Special			. Olive	t Ce	meter	ry	2/18	/2006	Wash	ingto	n, D.C.	
Baitimor	permit. Pages 1 Depertment of H Important: if ite eny injury or ot 2005.		21. Signature of Funeral Service Lice	1590		22	. Name ar	d Addres	s of Facilit	y T	he Burb	age	Funer	al Home	
מ	89 5 9		Work/	Julas,			108	Will:	iam S		Berlin,	_			
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each li	d the death	h. Do not ente	er the mod	e of dying	g, such as	cardiac o	r respiratory ar	rest,		Approxima Interval Be	ite atween
	Physician		Immediate Cause (Final disease or condition			Heart								Onset and	Death
	/Medical		resulting in death)	Due to (or as										years	i
	Examiner		Cogurantially list conditions	Mitral	Inst	ıfficie	ency							years	
	n #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):									
	cuted	Examin	triat initiated events	C											
Š	e exe ien a urial-i	Ĕ	resulting in death) Last	Due to (or as	a consequ	uence of):									
00/0	ficate be executed physicien and s the burial-transit	dicai		d											
õ	ntifica ng pl	Med	IF FEMALE:												
ŏ	thet the death certifi ed by the ettending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic pr	egnancy				2	23d. Date of	- ,	
	e des he et hed fo	sic	1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown	t time of de		Other (sp						Month	Day	Year
	bet the	Phy	9 Unknown								1				-
ກົ	The law requires thet the death certificate has been signed by the ettending tage? should be detached for use as	þ	Part II. Other significant conditions of	ontributing to death b	ut not resi	ulting in the ur	iderlying c	ause give	n in Part I.					e to the cause of	
coras	inper s sen s iould	Completed									1 U Y	es 2[_No 3□	Probably 4	Unknown
ပ် ဗ	hasbe ge 2 sh	pie									24a. Was a autop		24b. Were	autopsy findings to completion of	available
		Ö									perfor	med?	death	res 2□ No	Da030 01
	iician: Th certificete rector, pag	Be (25. Was case referred to medical examiner?						26. Place	of Death	(Check only or	<u> </u>			
> 5	Physician: rthis certific ral director,	2	1 ☐ Yes 2 ☐XNo	Hospital: 1 Inpatie	ent 2 🗆	ER/Outpatien	3 DC	Othe	r: 4 □ Nu	rsing Hon	ne 5 🖾 Resid	ence 6	Other (S	Specify)	
5 =	aling Phys		27. Manner of Death 1XXNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	2	8c. Injury Work	at ?	2	8d. Describe h	ow injury	occurred		
202	Attending r death. ector: Alter by the fune	Certification:	2 ☐ Accident investigation				М	1 🗆 Y	'es 2 □ l	No					
	irect irect	Ē	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inj building, et	ury - At ho c. (Specify	ome, farm, stre	et, factory	, office		2	Bf. Location (S City or Tow	treet and	Number of	Rural Route Nur	n <i>ber</i> ,
ב	ital curs of rai D														
	To the Hospital or Attending Physician: inin 24 hours elter death. To the Funeral Director: Alter this certific completely filled in by the funeral director,	edical	(Check only Z Medical Exar	ysician: To the best niner: On the basis o	f examinal	wledge, death	occurred	at the time	e, date and	d place, a	nd due to the o	ause(s)	and manner	r as stated.	9)
	the the I	Med	51.07	and manner st	ated.										-1
`	5 vit		29b. Signature and title of certifier	h !-	./		290	License	numoer	0	2	ego. Date A	signed (Mi	onth, Day, Year)	
•			NY	www	42		1	20	4/7	_		2	114	106	
	1 ,=		30. Name and address of person who			Photo:					nicki,	MD	, -,		
اكت	1 15		31. Date filed (Month, Day, Year)	IN AUC	#4		SU	2011	0, N	NO	21811				
	Sta Registr			32. R bistr	ar's Signa	k A	and !	0							

06-112	s H. Ll 4	оу	Unpend item#23a	Type or Prin 1,27,28a-f, per State of Ma	it in E	llack in 53,3/2/0 d / Depa	delible Ink of 11 ortment of 1	. Ensure All Health and M	Copies A	\re Legible ene	· =
AG			1 - For State Registrar				tificate of			g. No. UU (05963
			1. Decedent's Name (First, Middle, La	ist)					2. Date of Death Month	Dav _ Ye	3. Time of Death
	Physici /Medic		Charles Henr	y Lloyd					Februa:	ry 13, 20	006 7:55 A M
	Examin		4a. Facility Name (If not institution, giv 927 Pulaski Highv				4b. City, Town, of Edgew	or Location of Death		4c. County of D	
0	Funeral			Sex 7. Age 1 SatM 2 ☐ F	e (In yrs. I	ast birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
7	Director		355-42-9352 Usual Residence of Decedent	TQIW ZUT	43	Yrs.			July 7,	1962 U	tah
,	land w		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	after death with the Marylan or Iteme 23a or 28a-f ehow nither nast be notified at	tor	Maryland Harford		Edo	rewood					1 ☐ Yes 2√5xNo
	or 284	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of Wha	t Country?
	23a		1910 Hawthorn				210			USA	
	er dez	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		S. 13. \	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ♣ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	NO		I□Yes 2∏ No	Specify:		Specify:	White
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Iteme 23a or 28a-f ehow that the Medical Extrining rough be inclilled at	ted	15. Decedent's E	ducation		16a. Dece	lent's Usual Occup	pation	1	6b. Kind of Busine	
215	be filed within 7: stal Hygiene. od other then *n event, I're Medi	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT use retire	during most of workind)			
21	ygien yer th	S		2		Mecha	nic				e Service
pu	0 = 0 5	Be	17. Father's Name (First, Middle, Last	_				18. Mother's Name Estherle			
<u> </u>	12 should be filed within h and Mental Hygiene. 7 is marked other then * treumatic event, tre Mar	은	JOEL (nmn) LLo 19a. Informant's Name/Relationship	Oyd (Type Print)		19h Mailir	n Address (Street	and Number or Rura		- -	te Zip Code)
Ma	d 2 slith and 12 s						NAME OF TAXABLE PARTY.		o caracana		le. MD 21234
	permit, Pages 1 and 2 should be Department of Heelth and Menta Important: If Item 27 is marked any Injury or other treumstic especies.		Estherlee Lloyd 20a. Method of Disposition	/_rouer	20b. P	face of Dispo	Walther sition (Name of natory or other pla	BIVO. PL		Oc. Location - City	
ê E	Pages ent of nt: If ry or		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				Service (7-06 _T	owson, M	arvland
Baltimore,	mit.		21. Signature of Fune al Service Lice	onsee.	1222			ess of Facility Uneral Hor	and the same of th	Ondony 1	1.2012
ä	permi Depa Impo any Ir		Mulle a-	mark		1	.317 Coke	sbury Road	d. Abina	don, MD	21009
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused y one cause on each lin	the death	n. Do not ent	er the mode of dyi	ing, such as cardiac o	r respiratory arre themila	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a complicat				, , , , , , , , , , , , , , , , , , , ,			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):					
	Examine:	_	Fequentially flet conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as	a consecu	uence of):					
	ted nsit	nin	Cause (Disease or injury	244 (4, 45, 45							
ó	e executed ien and urial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a conseq	uence of):					
260	ysicie	-		d							
6876	death certificate be attending physicie d for use es the bur	Physician/Medica	IF FEMALE.								
Š	ith cei tendir or use	an/A	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	:y		23d. Date of Month	delivery Day Year
P.O. Box	e dea the at	sici	1 Yes 2 No	4□Pregnant at 9□ Unknown	time of de	eath 5	Other (specify) _			Worth	Day 100.
P. (w requires that the death cert been signed by the attendin should be detached for use		Part II. Other significant conditions	contributing to death b	ut not res	ultina in the u	nderiving cause or	ven in Part I.	23e. Did tob	acco use contribu	te to the cause of death?
ds,	signe d be	d by					, , ,		1 □ Ye	s 2 32 No 3[Probably 4 Unknown
Sor	w requ	lete							24a. Was an	24b. Wer	e autopsy findings available
Re	he lav e hes	Completed							autopsy	prior deal	to completion of cause of b?
ta	ifficet or. pa	e C	25. Was case referred to medical					26. Place of Death			Yes 2□ No
S	ding Physician: The lav h. Affer this certificete hes funeral director, page 2:	OB	examiner? 1 XXes 2 ☐ No	Hospital:	ent 2 🗆	ER/Outpatier	t 3 DOA				Specify) at scene
Ö	ng Ph ter th	n; T	27. Manner of Death 1_☐Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o	28c. Inju	rv at	28d. Describe ho	winjury occurred living in	Subject was not
sio	endir eath. or: Al	atic	2 Accident investigate	pn Fnd $2/13/0$		nd 7:45	AM 10	TVOC 2VINO	railer		
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use es the but	Certification;	3 Suicide 6 Could not 4 Homicide determined		c. (Specif	y)	eet, factory, office				r Bural Route Number, ulaksi Hwy
	spital ours a nerel l		29a. Certifier 1 ☐ Certifying P	hysician: To the best				· · · · · · · · · · · · · · · · · · ·	Edgewood,		er as stated.
	ne Ho n 24 h ne Fui	edical	(Check only one) 2 Medical Exa	miner: On the basis of and manner sta	f examina	tion and/or in	vestigation, in my	opinion, death occurr	ed at the time, da	ite and place, and	due to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	1	//	^		se number		d. Date signed (A	
			AIC	ANX	10	1	0.C.	M.E.	F	ebruary	13, 2006
			30. Name and address of person who	completed cause of	leath (Iten				_		1 01001
V)			31. Date filed (Month, Day, Year)	32#Registr	ar's Ciara		.11 Penn	Street, Ba	altimore	, Maryla	nd 21201
	Sta Regist		FEB 2 7 2	5.07	ar a Gigila	a de	A DED				

Amend Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend 1 tem 1 per doc 852 2-28-06 vt
State of Maryland 7 Department of Health and Mental Hygiene

Certificate of Death

					State of N	iai yiai	•	rtificate of	nealth and k f Death	nemai ny	Reg. No.	nnc	ns	964
			1. Decedent's Name	e (First, Middle, Lu	est) Mar	y Lo	ouise	Minkle		2. Date of D	eeth			Time of Death
	Physici		- Aichan	Marra Lon	ise Minkl					Month Februa	Dey	y Yea 5, 200		2:20 P.M.
	/Medic Examin		4a Fecility Neme (If			r)			4b. City, Town, or L		_	County of D		2.20 1.11.
4	LAGIIII				e Center				Emmitsb	uro		Freder	ick	
	Funeral		5. Social Security Nu			ge (In yrs.	last birthdey	If Under 1 Yea	If Under 24 Hrs.	8. Date of B				(State or Foreign
	Director		012-20-0	0147	1□M 2√2F		84 Yrs.	Months Day		Aug. 1				husetts
	arylend show			10b. County		10c. Ci	ty, Town or L	ocation					10d. Ir	nside City Limits
	Man	į	MD.	Freder	ick	En	mitsb	ırg					1	XÎYes 2 □ No
	or 28	5	10e. Street end Num	nber				10f. Zip Code			10g. Citi	izen of Whet	Country?	
	th wit	a D	335 Sout	th Seton	Avenue			2172	7		U.	.S.A		
9	72 hours after deeth with the Marylend naturel', or items 23e or 28e-f show alcel Examiner must be notified at	Funeral Director	11. Marital Status 1 X Never Marrie	ed 2 Married	12. Was Deceden Armed Forces 1 Yes 2 2 If Yes, Give	?	J,S. 13.	Was Decedent of If Yes, specify Cu	Hispenic Origin? (Sp ban, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Al Black, W		dian,
21215-0036	irel'.	d by	3 Widowed	4 ☐ Divorced	Year or Dates	:		100 22314	о зреспу.			Specify: W	hite	
5	72 h	Be Completed	(Speci	15. Decedent's E	ducation ede completed)		16a. Dece (Give	dent's Usual Occi	upation e <i>during most of work</i> red)	ing	16b. Ki	ind of Busine	ss/Industry	1
121	vithin hen.		Elementary/Secon	ndary (0-12)	College (1-4or				red)		E .	igious		~
	tygie Her ti	ပိ	17. Fether's Name (i	First Middle Lead	College	5+	T	eacher	40 10-11-1	·	Daug	hters	of C	harity
and	d of be	Be	,		•				18. Mother's Name			.,		
Ë	d Mai	P	Arthur J				1		Mary Ma			_		
Maryland	han han ris r		19a. Informent's Na	Camilla					et end Number or Run			,		Đ)
e)	Healt Healt In 2	-	20e. Method of Dispe			20h 8		osition (Neme of	on Ave., E	Date		cation - City	1727	<u> </u>
Baltimore,	ment of land: If its		1.2X Burial 2.□		Removel from State (y)	. (cemetery, cre	metory or other pl PH S P.H				•		. 21727
Bal	parmit. Departimportu		21. Signature of Fun	heral Service Lice.	skile.	ر1		2. Name and Add	ress of Facility SK	CILES FO				427
			23a. Part 1 Enter the	e disease, or com	plications that cause	d the deet	th. Do not en	ter the mode of dy	ring, such as cardiac	or respiratory a	rrest,		App	roximate val Between
	Physician		J		0.10 04400 011 0401								Ons	et and Death
4	/Medical		Immediate Cause (F disease or condition	Final	· End	Sta	00	ANT	ic StE	mas	2		1	veal.
1	Examiner		resulting in death)		a End	Due to (d	as a conse	quence of):						7
/	P	la l		_	, HUR	et	218	i cina -	SSELLE	10.			1	0112
	icate ba axecuted physicien and s the burial-transit	edical Examiner	Sequentially list con-	ditions,	0. 70	Due to (d	or es a conse						1	
60,	cien cien burial		Sequentially list con- if eny, leading to immoduse. Enter Under Cause (Disease or in	tying njury	C								1	
68760,	daath cartificate ba e attanding physicie ed for use as the bur	흥	that initieted events resulting in death) La		0.	Due to (o	r as e conse	quence of):						
	# D 8	5			d									
Вох	ath c	a l			.								1	
o	the a	yslo	Part II. Other signific	cent conditions	contributing to death	but not res	ulting in the u	inderfying cause g	iven in Part I.	23b. Did	tobacco	use contribu	ite to the	cause of death?
Д.	v requires that tha daath car been signed by the attandit should be datached for use	Completed by Physician/	fali	nona	ryHy	pe	Jos	Sion	- DEcel	2 10	Yes 2	⊠ No 3□	Probably	4 Unknown
of Vital Records,	aquire en si ould l	<u>8</u>	Art	000	(, (/	1	2/1			24a. Was	an autop	sy 241	b. Were au available	topsy findings
ပ္ပ	aw re as be 2 sh	ble	11/21	at g.	pr.110	1	on			, po			complet of deeth	e prior to ion of cause ?
ď	The igw ate has b	Š	Signif	om:	clupi	10	01 -1	7	10908	1 🗆	Yes 20	X No	1 🗆 Yes	2 □ No
ita	artifice ctor,		25. Was case referre	ed to medical			271	coure	26. Place of Deatl	h (Check only	one)			
Ž	ysic is ce dire	ဥ	1 ☐ Yes 2 🖾 N	No	Hospital: 1 ☐ Inpat	ient 2 🗆	ER/Outpatie	nt 3 DOA	ther: 4 Nursing Ho	me 5□Resi	idence 6	3 □Other (S)	pecify)	
0	Attending Physician: or death. ector: After this certification that funerel director,		27. Manner of Death 1 ☑ Natural	5 Pending	28e. Date of Inj (Month, De	ury ev Year)	28b. Time o	f 28c. Inju		28d. Describe				
0	andir parth. ha fu) at	2 Accident	investigation	n				Yes 2□No					
Division	r Att	¥ l	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined		jury - At he	ome, farm, st	reet, factory, office		28f. Location (City or To	Street and	d Number or	Rural Rou	te Number,
	ital or is afte is Dir is in in	3												
	To the Hospital or Attending Physician: The igw within 24 hours after death. To the Funetal Director: After this certificate has completely filled in by tha funerel director, page 2	edical Certification:	29a. Certifier 1 (Check only 2 one)	1⊠ Certifying Ph 2□ Medical Exam	ysicien: To the best niner: On the besis of and manner s	of examina	wledge, deat tion end/or in	n occurred at the t vestigation, in my	time, date and place, opinion, death occurr	and due to the ed et the time,	ceuse(s) date and	and manner place, end d	as stated. lue to the	cause(s)
	Vithi To th		29b. Signature and ti	itle of certifier			^	29c. Licer	se number		29d. Date	e signed (Mo	onth, Day,	Year)
			Ba	11 tas	Ikhan	ReD.	for TI	EUR H	094403	>	FEBRU	JARY 1	6, 20	06
•	V		30. Name and eddres	ss of person who	completed cause of	deeth (Item	23a) (Type,	Print) / 7	-1-123	W287	-ur	am	STRE	EET
	1		BONITA.	J. JCR	EmpEL	FER	TIEA	RAD E	www.TSF	BURA.	M	D 21	クス	>
	Stat	C	31. Date filed (Month		32. Regis	rar's Signa	iture	1-1-	7-284	/	, .	-	-	
	Registra	ır	ŀ	FEB 2 8	2006	VS. a	15 6	DENEL						

ORIGINAL

		1	For State Registrar	State	of Maryland		artment of H		Лental Hygie Reg	ene 006	05965
	Physicia		1. Decedent's Name (First, Middle	e, Last)	M-1.				2. Date of Death Month Feb. 9	Day Yea	3. Time of Death
	/Medic	al	Virginia			azzo	4b. City, Town, or	Location of Docath		4c. County of De	2304 M
1	Examin	er	4a. Facility Name (If not institution Shady Grove				Rockv			Montg	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,)		birthplace (State or Foreign Country)
	Director		209-10-2533	1 □ M 2 X F	94	Yrs.	Months Days	Hours Min.	12/22	/1911 P	A. A.
	pue *	1	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	f sho	ō		gomery	Mo	ntgon	nery Vil	lage			1 ☐ Yes ¾☐ No
	r 28a	Director	10e. Street and Number				10f. Zip Code		100	g. Citizen of What	Country?
	be filed within 72 hours after death with the Maryland Hygiene. Id other then "naturel", or items 23e or 28e-f show to other then "naturel", or items 20e or 28e-f show event, the Medical Examinant and be notified.	alD	1930 Watki	ns Mill	Road		2088			USA	
	tems	nuer	11. Marital Status	Armed F		S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	safte ; or h	y Fu	1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes, G	2 X No live Dates:	-	1 ☐ Yes 2 % No	Specify:		Specify:	White
21215-0036	2 hou	Completed by Funeral	15, Deceder	nt's Education		16a. Dece	dent's Usual Occupa	ation	16	3b. Kind of Busine	ss/Industry
215	thin 7. e, en "n	ple	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)		kind of work done of		\"Ig	Departm	ent Store
2	led wi ygien her th		12	(and)		GTO	ssar Bro		ne (First, Middle, Mi		
and	l be fil ntal H ed oth	Be	17. Father's Name (First, Middle, Joseph Mila						Dicara	alden Sumame)	
Maryland	should nd Me mark mark	ဥ	19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	ng Address (Street a		ral Route Number,	City or Town, State	a, Zip Code)
Z	alth ar		Stanley Roc/	Nephew		414	Kenwood	Avenue	Johnst	own, PA.	15909
ore,	of He of He rother		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from	n State Ce	emetery, crei	sition (Name of matory or other plac			oc. Location - City	
Ĕ	Pag ment lent: i		*4 □ Donation 5 □ Other (Specify)	St		nony Cem			Johnsto	
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Marel Hygiens. In the mortent: if item 27 is markend other than "naturel", or items 23a or 28a-f show mportent: if the conference of the trian than "naturel", or items 23a or 28a-f show any houre or other treumatic event, the Macilical Examinar conference on any houre or other treumatic event, the Macilical Examinar conference on any houre.		21. Signature of Funeral Service	4 01							ICE, P.A.
	402.00		23a. Part1. Enter the disease, of	r complications that	caused the death	n. Do not en	241 Col	umbia E	Slvd.Sil or respiratory arres	ver Spr	ing Md20010
			Immediate Cause (Final	t only one cause on	each line.	due	- 1 M	N. Common			Interval Between Onset and Death
2	Pnysician /Medical		disease or condition resulting in death)	aDue to	o (or as a consequ	uence of l:	rhythm	(1)			
	Examiner		Sequentially list conditions	b							
	sit s	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a consequ	uenda of):					
_	xecute and II-tran	Examiner	that initiated events resulting in death) Last	c	o (or as a consequ	uence of):					
8760,	icate be executed physician and s the burial-transit	cal E		d							
68	uficate ig phy as the	e e									
Вох	death certifica e attending ph d for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna birth 2 Petal		□Ectopic pregnancy			23d. Date of Month	delivery Day Year
Э	the dea by the at ached fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unk	gnant at time of de known	eath 5[Other (specify)				,
Д.	that the de sed by the a detached f		Part II. Other significant condit	ions contributing to	death but not resu	ulting in the u	inderlying cause give	en in Part I.	23e. Did toba	acco use contribut	to the cause of death?
ds,	uires tha signed ild be dei	d by	Sensis						1 ☐ Yes	2 □ No 3 □	Probably 4 Unknown
Record	law requires that as been signed b 2 should be deta	Completed	huper	natremic	2				24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
Re	The his age	mo	dekudi	ation		-			perform	ed? death	1?
Vital	icien: T	BeC	25. Was case referred examiner?				011		ath Check onl one		
of V	Physicien: this certific ral director,	유	1 ☐ Yes 2 ☑ No		3.1.7.1.1.1.1	ER/Outpatie			lome 5 Resider		(pecify)
		tlon:	27. Manner of Death 1 □ Natural 5 □ Pend		e of Injury onth, Day Year)	Injury	Wor	k? Yes 2∐No	200. 20000000	wingary coccurred	
Division	i or Attendii after death, Director: A d in by the fu	flca	3 Suicide 6 Could	I not be 28e. Pla			reet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
Ö	s after s after of Direct	Certification;	4 Homicide	Duli	Iding, etc. (Specify	Y) 			City of 10 min,	State)	
	To the Hospitei or Attending within 24 hours after death. To the Funerel Director: After the Funerel Director or Attention by the fune bompletely filled in by the fune		29a. Certifier 1 ☐ Certify (Check only 2 ☐ Medica	ing Physicien: To to Examiner: On the	he best of my kno basis of examina	wledge, dear	th occurred at the tire	ne, date and place pinion, death occu	e, and due to the cau	use(s) and manne te and place, and	r as stated. due to the cause(s)
	the hin 24 the f	Medical	29b. Signature and title of certif		anner stated.		29c. Licens	e number	29	d. Date signed (M	onth, Day, Year)
b	765			mito	M	\rightarrow	100	52887	1	Plantain	110.2006
	5		30. Name and address of perso	who completed ca	use of death (Item	n 23a) (Type	Print)	1000		Cornar	
)	9901	Mod.	ical Cor	ter Dr.	Rockvil	le,Md 2	0850
		ate	Lyon Cal 31. Date filed (Month, Day, Yea FEB 1	2006	Registrar's Signa		reter				
	Regist	rar	I LU I	, 2000		1					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Ruth Meyers 9, 2006 12:00 P.M February /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Casey House Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. | 22, 1 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 3.F 577-58-2852 93 Director 1912 New York Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23s or 28s-f show eny injury 2021 in the Marylan Examines in neather northed as once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Rockville Director Montgomery 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6121 Montrose Road #4718 20852 United States Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify à Specify: White 3 ∑Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Clerical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fanny Shapiro Benjamin Levine ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 510 Broadwood Drive, Rockville, MD Michael A. Meyers/ Son 20a. Method of Disposition Geo. Wash. University 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 2006 4 Donation 5 Other (Specify) Medical Center Signature Funeral Service Lices 22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Debility /Medical Due to (or as a consequence of): **Examiner** Osteoporosis Sequentially list conditions, lary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physicien and for use es the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the aid be detached for 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 27 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No 207 No To the Hospitel or Attending Physician: within 24 hours efter death.

To the Funerel Director: After this certifical completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Tother (Specify) HOSpice 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation Injury M 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D35635 February 9, 2006 Scompleted cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road 30. Name and address of person Joseph Kaplan, M.D. 20855 Rockville, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 13 2006 Registrar

DHMH 17 Rev 1/2001

		1	For Amend Items 236;28 025 Apple State Registrar	ME,039 59 Cer	Btr 03d2df/l06athi band M <i>tificate of Death</i>	lental Hygiei Reg.	2 22 22 28	05967		
Physician			Decedent's Name (First, Middle, Last) Conway Alexander Mowbray	2. Date of Death Month Feb.	3. Time of Death					
	Medica xamine		Ia. Facility Name (If not institution, give street and number) 7 E. Washington St., Apt. 608	TCD.	14 2006 0800 A ^M 4c. County of Death Washington					
	neral ector		5. Social Security Number 220–58–4635 1 M 2 F 52	. last birthday) Yrs.	Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 25,	9. Birtho	place (State or Foreign		
Maryland	TOURING AL		Usual Residence of Decedent 10a. State 10b. County 10c. C MD Washington	ity, Town or Lo Hager	cation			10d. Inside City Limits 1		
death with the Maryland ms 23a or 28a-f show	2.4	i Director	10e. Street and Number 7 E. Washington St., Apt. 608	10g.	Citizen of What Cou	ntry?				
₽ ₹	Examiner m	by Fur	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in the Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	'	Mas Decedent of Hispanic Origin? (Sp. f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: W			
Maryland 21215-0036 and 2 should be filed within 72 hours after than Mental Hygiene.	within 72 hous iene. r than "natural", fre Madical Ex	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 2	(Give	ient's Usual Occupation kind of work done during most of work. DO NOT use retired) UDETVISOT		Governme			
faryland 2121 2 should be filed within and Mental Hygiene.	item 27 is marked other than other traumatic event, U.S.M.	To Be C	17. Father's Name (First, Middle, Last) Owen Henry Mowbray		18. Mother's Name	e (First, Middle, Maid ene Harba				
re, Maryla	- =		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Candice E. Mowbray / Daughter 806 Mulberry Ave. Hagerstown, MD 21742							
Baltimore, Demit. Pages 1 ar Department of Hear	Important: If Item 2 any injury or other 20059.		20a. Method of Disposition 20b.	Place of Dispo cemetery, crer Se Hil	natory or other place) 1 Cemetery 2/17	/2006 Ha	agerstown,	MD		
Baltimo	any inj 2002		21. Signature of Europe I Service Licensee	3	05 N. Potomac Str	eet, Hage	rstown, M	neral Home 21740 Approximate		
			In shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease) or condition as a Lung Condex with Attsts:							
8760, sate be executed Withdrawalian and		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
Division of Vital Records, P.O. Box 60 To the Hospital or Attending Physician: The law requires that the death certific To the Programme Attendament to the Control Discovery Attendament and the physician page 1970.	the attending p	Completed by Physician/Me	IF FEMALE: 23c. If yes, outcome of preg 23c. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of preg 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of define Month	Day Year		
rds, P.	n signed by	ed by Ph	Part II. Other significant conditions contributing to death but not re	esulting in the u	nderlying cause given in Part I.		cco use contribute to	the cause of death? bably 4 □Unknown		
I Recoi	ate has bee page 2 sho	Complete	Wand WECTON			24a. Was an autopsy performed 1 ☐ Yes 2 ☑	d? prior to co	opsy findings available ompletion of cause of 2 No		
Vita	s certifica director,	To Be (25. Was case referred to medical examiner? 1 ★ Yes 2 ★ Hospital: 1 Inpatient 2	☐ ER/Outpatier	Other	h (Check only one)	e 6 □Other (Spec	ify)		
Division of Vital Records, P.O. tor Attending Physician: The law requires that the district clearly.	ctor: After thi y the funeral	Certification; T	27. Manner ef Death 1 ☑Natural 2 ☐ Accident 3 ☐ Suicide Could not be determined	home, farm, st	Work? M Yes 2 □ No		et and Number or Rui	ral Route Number,		
Div	uneral Dire									
Fo the H	To the F complete	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. License number		. Date signed (Month	, Day, Year)		
	. 0				D005952		2/14/06			
5H-2	2+/		30. Name and address of person who completed cause of death (It 24 N. Walnut St. Hagerstown, N	ID 21740		ER, M.D. 046				
R	Sta Registr		31. Date filed (Month Day Year) 4 2006 32. Registrar's Sig	nature	perke					

		•	For State Registrar	State of Marylar			nt of Healt te of Dea			giene Reg. No.	006	05968
	Physicia	an	Decedent's Name (First, Middle, Last)	ali			-		2. Date of Dea	ith Day	O/ Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give si	treet and number)	KILI	4b. Cih	, Town, or Locat	ion of Death	EBRU		ounty of Deat	06 10:30 AM
	Examin	er	BALTIMORE WASHINGTO		ENTER	GL	ENBUR	RNIE		Ar	UNE F	RUNDEL
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) 68 Yrs.	If Unde Months		ırs Min	B. Date of Birtl (Month, Day Sept. 1	/ Yearl	Co	hplace (State or Foreign untry) Shington, DC
			Usual Residence of Decedent								- nas	10d. Inside City Limits
	with the Maryland is or 28s-1 show	ō	10a. State 10b. County Maryland Anne	Arundel	ty, Town or Loc	ation ader	ıa					1 ☐ Yes 2 No
	th the h	Irect	10e. Street and Number		140		p Code			10g. Citize	on of What Co	untry?
	death with	raiD	21 Stone Drive				21122				USA	
336	or its	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 	J.S. 13. V		edent of Hispanic ecify Cuban, Mer 2 1 No Spe	c Origin? (Spec xican, Puerto R cify:	ofy Yes or No- lican, etc.)		I. Race - Ame Black, White Specify: Whi	e, etc.
IANE 1 21215-0036	72 net	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	ent's Us	ual Occupation ork done during use retired)	most of working	g	16b. Kind	d of Business/	Industry
1ANE 21215-0	within ene. then "	Jdmc	Elementary/Secondary (0-12)	College (1-4or 5+)			rocesso			Tn	surance	2
Di and 2	e filed al Hygid other vent, I	BeC	17. Father's Name (First, Middle, Last)					tother's Name	(First, Middle,			
ylar	should b nd Menta marked imatic a	2	Francis Everett L					therine		-	- 0	7.0.11
Mag 1	nd 2 sh Ith and 27 is m r traum		19a. Informant's Name/Relationship (Type Hayden Dale Midki			-	s (Street and Nu Drive,					
NIDKIF Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if itam 27 is marked other than any injury peopler fraumatic event, Itam once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Place of Dispos cemetery, crem ropolitan	atory or	other place)	Februa 200			ation - City or	Town, State Virginia
MIT	permit. Departminports any inju		21. Signature of Funeral Service License	e	Fr 50	Name anci	ind Address of F S J. Co Liversit	aculity 11ins F y Blvd,	uneral W, Si	Home 1ver	Inc Spring	g, MD 20901
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	eations that caused the deal cause on each line.	^		de of dying, such	h as cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
68760,	Medical Examiner be executed by Medical burial-transit site burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Cardia Cercic Shock, Due to (or as a consequence of):									
_		w	VE 551111.6									
P.O. Box	Attanding Physician: The law requires that the death certific robath. actor: After this certificete has been signed by the etlending p to the funeral director, page 2 should be detached for use as it	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Sc. If yes, outcome of pregn 1 Live birth 2 Fet: 4 Pregnant at time of a 9 Unknown	al death 3 🗌	Ectopic Other (s	pregnancy specify)			23	d. Date of deli Month	ivery Day Year
	ires that signed b d be deta		Part II. Other significant conditions conditions	tributing to death but not re-	sulting in the un	derlying	cause given in P	art I.			e contribute to	the cause of death?
Sorce	w require been si should I	eted	PHONE CITE	receptant	3				24a. Was	ī		. /-
al Rec	sician: The lav certificete has irector, page 2	e Completed by	Of Wa						autop perfor 1 Yes	200 No	death?	topsy findings available completion of cause of
<u> </u>	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 % npatient 2] ER/Outpatient	3 🗆 🗆	Other	Place of Death Nursing Hom			□Other (Spec	cify)
0	ding Phys h. After this funeral di		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?	28	8d. Describe h			
Division of Vital Records,		Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	M eet, facto	1 ☐ Yes		8f. Location (S City or Tow	Street and m, State)	Number or Ru	ıral Route Number,
	na Hospital or 24 hours afte na Funeral Dir sietely filled in	ledical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurre	d at the time, dat n, in my opinion,	te and place, ar death occurre	nd due to the o	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)
	To the within 2 To the comple	W	29b. Signature and title of certifier			2	c. License numi		1		signed (Monti	
	10		rung stalle	2 'M)	00: \ 7	Data ::	D0036	1144	F	ebru	ory 6	2006
			JACIA GAVIRIA	mpleted cause of death (Ite		Sp 1	ol Dri	ve 6	leibu	MP	MD	2006
	Sta		31. Date filed (Month, Day, Year) FFB 1 0 20	32 Registrar's Sign	ature	sele	P					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1. Decedent's Name (First, Middle, Last) Maria

Physician

/Medical

Examiner

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

Mattovich

2. Date of Death

Reg. No.

3. Time of Death

Feb. 4,2006

11:42aM

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death Montgomery

5. Social Security Number 7. Age (In yrs. last birthday)

Α.

 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Dec.31,1926 Peru

> 10d. Inside City Limits 1 Yes 2 No

> > 10g. Citizen of What Country?

Peru

Specify:

14. Race - American Indian, Black, White, etc.

White 16b. Kind of Business/Industry

Own Home

Aida Cabeduque

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20c. Location - City or Town, State

PHTLIPADERINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval Between Onset and Death

> 23d. Date of delivery Month Day

Year

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

28d. Describe how injury occurred

29d. Date signed (Month, Dey, Year)

0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D52261

Feb.7,2006

Alan R. Segal MD

31. Date filed (Month, Day, Year) 10 FEB 2006

1500 Forest Glen Rd Silver Spring, Md 20910 32. Registrar's Signature cartes

DHMH 17 Rev 1/2001

State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:30 P^M McCABE 2006 BRASURE FEB. 11 MADELYN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WORCESTER BERLIN 509 WILLIAMS ST. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Months 1 □ M 2 X F DELAWARE JAN. 15, 1921 Director 214-36-5266 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir then "natural", or items 23a or 28a-f ehow The Medical Examinational be notified at 1 XYes 2 □ No BERLIN WORCESTER MARYLAND Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21811 USA 509 WILLIAMS STREET death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after d al Hygiene. other then "natural", or item 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. Specify: Baltimore, Maryland 21215-0036 ά WHITE 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) OWNER & OPERATOR HAIR SALON 12 item 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be es 1 and 2 should be fi of Health and Mental H if item 27 is marked otl ELIZABETH LYNCH BRASURE **JAMES** Α. ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nama/Relationship (Type, Print) 13019 DRUM POINT RD., OCEAN CITY, MARYLAND 21842 STANLEY B. McCABE/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Importent: if itel
any injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State BISHOPVILLE CEM. 2/15/06 BISHOPVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 MO1343 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPERTEMSIUM Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 🗆 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. been signed þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No certificate or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ပ this funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a To the Funerel D Tertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D27993 2-13-06 SW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philadelphia Ave, OFFAN GIVY, Mr. 21842

Registrar DHMH 17 Rev 1/2001

State

WATERS

FEB 1 4 2006

TEPHEN

31. Date filed (Month, Day, Year)

Mis

32. Registrar's Signature

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2/3/06	
NOLAN 2/3/06	
DAVID	

									Are Legible.	17 m 17 m
			For State Registrar	ate of Maryl		partment of F ertificate of		R	eg. No.	009/1
	Physicia /Medic		Decedent's Name (First, Middle, Last) David Nolan					2. Date of Dea Month Februar	y 3, 2006	3. Time of Death 1:03 a ^M
	Examin Funeral Director	er	4a. Facility Name (If not institution, give stree Suburban Hospital 5. Social Security Number 541-90-7551 6. Sex	7. Age (In)	yrs. last birthda 47 ^{Yrs.}	Bethes		8. Date of Birth (Month, Day 12/03/1	Year) Co	
	0		Usual Residence of Decedent 10a. State 10b. County	10c.	. City, Town or	Location				10d. Inside City Limits
	the Mary 28a-f sh	rector	Maryland Montgomery 10e. Street and Number	I	Rockvi1	1e 10f. Zip Code		1	l 0g. Citizen of What Co	1 ☑ Yes 2 ☐ No ountry?
	h with	al Di	5905 Holland Road			20851			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injugy a gather traumatic event. In Medical Examinar must be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 1	Vas Decedent Ever i nmed Forces? ☐ Yes 2(X)No i Yes, Give rear or Dates:	in U.S. 13	3. Was Decedent of a lif Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spinan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Cau	e, etc.
2-0	72 hou	ted	15. Decedent's Educatio (Specify only highest grade cor	n nnleted)	16a. De	cedent's Usual Occu	pation during most of work	ina	16b. Kind of Business	
Maryland 21215-0036	hen "	mple		College (1-4or 5+) 5+			during most of work ed) ce Office		U.S. Gover	nmen <i>t</i>
d 2	filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Last)	JT	Fore	ign servi	18. Mother's Name			imeric
lan.	Aental Aental rked c	To Be	Sidney David Nolan J	r.			Mary Lee	Nolan		
lary	2 shoil and h		19a. Informant's Name/Relationship (Type, I	Print)	1	•			r, City or Town, State, .	Zip Code)
e, r	1 and Health em 27 ther to		Mariana Nolan / Wife 20a. Method of Disposition	20	b. Place of Dis	position (Name of	Road; Rocl	cville, Date	MD 20851 20c. Location - City or	Town, State
nor	ages ent of ht: # it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State		oin Crema	tory 2/10	/2006	Brentwood,	Marvland
Baltimore,	permit. P Departm importar any inju		21. Signature of Funeral Service Ligensee			22 Name and Addr Simple Tr	ess of Facility ibute Fune	eral and	l Cremation ville, MD 2	Center
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1	rnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. $\underline{\underline{M}}$	itral Regi		ion				5 years
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of	a fee	ation: To	1 X 198 2 190	1 ☐ Inpatient 8a. Date of Injury (Month, Day Yea	2 ER/Outpa 28b. Time Injur	e of 28c. Injury	4 Nursing no		lence 6 □Other (Speniow injury occurred	ecity)
Division	if or Attendia after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	8e. Place of Injury - building, etc. (S)		street, factory, office	•	28f. Location (S City or Tow	Street and Number or R vn, State)	ural Route Number,
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Physicia (Check only one)							
)	To the vithin compl	Me	29b. Signature and title of certifier	-uD		29c. Licer D 37	891		29d. Date signed (Mon 2/6/06	th, Day, Year)
•	15		30. Name and address of person who compl A. Rajvanshi, M.D.	121 Con	gressio	nal Lane	#409; Rocl	kville,		
	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 8 200	32. Registrar's S	Signature	Sparke				

	-		For Stata Registrar	State of	f Marylar		artmeni rtificate			and Me	ental Hyg R	jiene _{eg. No.}	06	059	12
			Decedent's Name (First, Middle, Last)	-							2. Date of Dea		Vaar	3. Time of	Death
	Physicia		E11a	Mae Os	shorne					E	Month Tebruar	v 21	Year 2006	0645	AM
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or l	ocation of			1	ounty of Death		
		•	118 Big Elk Cha	oel Roa	ad		E11	cton				C	ecil		
	Funeral		Social Security Number 6. Sec.		7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth	Year)	9. Birth	place (State o	r Foreign
	Director		410-34-2715]M 2∏F	84	Yrs.	WOTUTS	Days	110010	1	April 3	, 192	1 Ten	néssee	
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	show	_	10a. State 10b. County			ity, Town or Lo	cation						:	1 Tes	•
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3	be filed within 72 hours after death with the Maryland tal Hygiene. It was not a death at the had refer to a death at the Madical Examinating the notified at event, the Madical Examination to set the notified at		15. Decedent's Edu		a103.	16a, Dece	dent's Usua	I Occupat	tion			16b. Kind	of Business/li		
က်	n 72	Completed	(Specify only highest grad	e completed)		(Give	kind of wor DO NOT us	k done du	iring most	t of workin	g			,	
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7 0	filed Hygi sther ant.		17. Father's Name (First, Middle, Last)	-			- p		18. Mothe	er's Name	(First, Middle,				
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. and Mental Hygiene. Is marked other than "natural", or flams 23a or 28a-f show aumatic event. If we Macigal Examinar inust be notified at	То Ве	Stanley T. Cres	3					01	lie I	Davidso	n			
<u></u>	should ind Men s marke umatic	-	19a. Informant's Name/Relationship (T)			19b. Mailir	ng Address	(Street ar	nd Numbe	er or Rural	Route Numbe	r, City or To	own, State, Z	ip Code)	
	D = D =		Jeanette O. Loga	an/Daug	hter	6190	Tele:	raph	Roa	d E1	lkton, l	Mary1	and 21	921	
a)	- ± 5 5		20a. Method of Disposition		20b.	Place of Dispo	sition (Nan	ne of		ebrü		20c. Locat	tion - City or T	Town, State	
5	permit. Pages Department of (Important: If it, any injury or o		1 ☐ Burial 2 X Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	lemoval from	State	.A. Ferri	•			22, 2	•	Penn	Chest sylvan	er, ia	
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m.	deat e atte	ICIa	in the past 12 months? 1 ☐ Yes 2 ☑ No		nant at time of		Other (sp						Month	Day 1	/ear
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æ	sician: The law s cert/licate has b lirector, page 2 s	mo;	27)		U				perfor	med? 2 🖟 No	death?	2 No	
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>	lysica lis ce direc	To	1 Yes 2 No	lospital:	Inpatient 2[☐ ER/Outpatier	nt 3 DC	Othe	r: 4 🗖 Nu	ursing Hon	ne 5 Aesid	ence 6[Other (Spec	city)	
0	ng Ph ter th neral	ü	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury	f 2	8c. Injury Work	at ?	2	8d. Describe h	ow injury o	occurred		
<u>Ö</u>	andir ath. or: Af	atlc	2 ☐ Accident investigation				М		es 2 🗆 i	No					
Division of	er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place build	of Injury - At ing, etc. (Spec	home, farm, str	reet, factory	, office		2	28f. Location (S City or Tow	Street and h m, State)	Vumber or Ru	ral Route Num	ber,
	tal or rs aft af Di ed in	Cer													
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Cartifying Phy (Check only 2 Medical Exam	nar: On the b	asis of examin										:)
	the F the F	Med	one)	and man	ner stated.			License	number			20d Data	signed (Month	Day Voor	
	To To COL	Σ	29b. Signature and title of certifier	P.10	Ver-	T mi	290	License	Tuiliber	30	7	(a) nate s	signed (Month	Lay, rear	
			Jeynye 112	- ('				~	2	, _	1	14/0	21/2	000	·p
	7		30. Name and address of person who c	ompleted caus	se of death (Ite		Print)	0.0	4 A	ve i	ELK	T074	(mi)	2190	2/
			31. Date filed (Month, Day, Year)	7711		(A STATE OF THE STA	ne,							
	Sta Registi		FFR 9 8 200	Sur	Registrar's Sig	Got									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Trem 9 per fh 9852 2-28-06 vt
State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No." 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** GWENDOLYN LUCILLE PRYOR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AlleGANI omberLance of The Inder 24 Hrs. le AR+ 405 Dita Cred 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 1 □ M 2 X F Yrs. 213 22 4494 78 DC. Director JUNE 13 1927 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other then "natural", or items 23a or 28a-f ehow 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MARYLAND ALLEGANY LaVALE 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number **502 FAYETTE STREET** 21502 U.S. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: ģ Specify: WHITE 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be CHARLES BARRET CORA KEILING ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 Is
eny injury or other trau 238 EAST GATES DRIVE, MORGANTOWN, WV Disposition (Name of Date 20c. Location - City KELLY PRYOR / DAUGHTER 26508 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State SUNSET MEMORIAL PARK 2/24/06 CUMBERLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 W. MAIN STREET Sowers TILL M00547 SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Can

Due to (or as a consequence of): **Physician** 2 months Cancer /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 Yes 2 No 3 Probably To the Hospital or Attending Physicien: The law require within 24 hours after death.

To the Funerel Director: After this certificate has been six completely filled in by the funeral director, page 2 should 1 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔏 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00055325 Feb. 21, 2006 MD worsock then 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIN MD 48 Tarn Terrace Frostburg WONSOCK MD21532 32. Registrar's Signature 2 8 State 2006

Registrar

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Records,

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 09, 2006 **Physician** 4:47 Рм STEVEN PAYNE, JR. GARRY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Overholt Road at Gordy Road Rehobeth Somerset If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□F Yrs 8/4/1988 Virginia Director 212-39-3995 17 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County is 1 and 2 should be filed within 72 hours after death with the Maryla of Heelth and Mental Hygiene. Item 27 ie merked other then "naturel", or items 23a or 28a-1 ehov other treumstic event, Ite Medical Examiner must be notified at 1 ☐ Yes 2 XNo MD Worcester Pocomoke City Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4925 Stockton Road 21851 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student High School 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Garry Steven Payne, Sr. Margaret Elizabeth Howell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Depertment of Heelth at important; if item 27 is eny injury or other treusonce. Garry Steven Payne, Sr. (Father) 4925 Stockton Rd., Pocomoke City, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State First Baptist Cemetery 2/13/2006 Pocomoke City, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Holloway Melson Funeral Home, P.A. Dean 103 Linden Ave., Pocomoke City, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Due to (or as a consequence of) Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed nding physiclen end use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Day 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of d ath?

1 ★ es 2 □ No page 2 autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one 2 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) at scene 1 TyYes 2 □ No within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury FOUNMONTH, Day Year) 2 - 9 - 06 28d. Describe how injury occurred 7 car, Descased dinner 07 car, Simuch Fixed Ob 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 2-9-06M or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ZNO investigation Objects 25 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number City or Town, State) OULYNO + 120.6 determined 4 Homicide Gordy Road Pocomole, MD 2185, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 10, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 190GA 1 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year) FEB 1 0 2006 32. Registrar's Signature

			For State Registrar	State of Ma		partment of ertificate of		nd Mental Hygier	1000	05975
	Physici /Medio		1. Decedent's Name (First, Middle, La Tammy Jean Price	,				2. Date of Death Month FEBRUARY	12, 2006	3. Time of Death 12:06P. M
	Examir		4a. Facility Name (If not institution, gi UNION HOSPITAL	ve street and number)		4b. City, Town, ELKTON	or Location of [4c. County of Death	1
	Funeral Director			Sex 1 □ M 2 💢 F	e (In yrs. last birthda 41 Yrs	Months Davs		Hrs. 8. Date of Birth (Month, Day, Ye. 5/18/1964	ar) Coi	pplace (State or Foreign intry) yland
	ehow	25	Usual Residence of Decedent 10a. State 10b. County Maryland Cecil		10c. City, Town or Elktor					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the N s or 28s-f be notifi	Direct	10e. Street and Number 600 Bouchelle Roa			10f. Zip Code			Citizen of What Co	untry?
390	d within 72 hours after deeth with the Maryland glee. Than "natural", or Itams 23e or 28e-f ehow the Madical Eraminar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1		21921 3. Was Decedent of If Yes, specify Cul	ban, Mexican, F	Uni ? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer Black, White	ican Indian, , etc.
121	within jiene. r than *	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5	+) (G life	cedent's Usual Occu ive kind of work done b. DO NOT use retire	eduring most of ed)	f working	Kind of Business/I	
yland	s 1 and 2 should be filled f Health and Mental Hygis ftem 27 is marked other other traumatic event, I	To Be C	17. Father's Name (First, Middle, Las John Dale Eldreth					Name (First, Middle, Maid Ley Richardso		
, Mar	and 2 sho ealth and m 27 is me		19a. Informant's Name/Relationship Shirley Eldreth/m					or Rural Route Number, Cit North East,		
	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other to		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Content of the Conten		cemetery, o	sposition (Name of Frematory or other pl St Method Netery	ist 12	ruary 17, No		own, State , Maryland
Balt	permit. Departr Imports any inj		21. Signature of Fugeral Service U.S.	nsee		22. Name and Add		Crouch Funer reet,North E		land 21901
F	Physician		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused one cause on each lin	10.	TIPLE				Approximate Interval Between Onset and Death
	death certificate be executed be attending physician and office use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of): a consequence of): a consequence of):		77			
.O. Box 6	at the death certific by the attending p tached for use as in	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 1990Inknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify)	су		23d. Date of delin	very Day Year
Δ.	law requires that the as been signed by th 2 should be detache	ρ	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause g	iven in Part I.		× a	the cause of death?
Œ ,	The ete h page	Completed						24a. Was an autopsy performed 15 Yes 2	prior to o death?	opsy findings available ompletion of cause of
f Vital	ysician: Th is certificete director, pag	To Be	25. Was case referred to medical examiner? 1∑ Yes 2 □ No	Hospital: 1 ☐ Inpatie	nt 2 ី ER/Outpa	tient 3 DOA	ther	Death (Check only one) ing Home 5 ☐ Residence	6 □Other (Spec	ıfy)
Division of	To the Hospital or Atlending Physician: within 24 hours atter death. To the Funaral Director: After this certifical completely filled in by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigator 3 Suicide 6 Could not	De 290 Place of law	· 17	y y	Yes 2 XNo		21AW 570	
, N	ospital or A hours after unaral Dire ly filled in b	cai Certi	4 Homicide determined 29a. Certifier 1 Certifying P (Check only 2 Temperature)	building, etc	of my knowledge, de	DWAy	time, date and p	place, and due to the cause	(s) and manner as	Stated.
	To the Hi within 24 To the Fi complete	Medical	29b. Signature and title of certifier	and manner sta	ited.		nse number	occurred at the time, date a	and place, and due Date signed (Month	
	,		30. Name and address of person who	pletod as so of d	eath (Item 22a) (Tim		С.М.Е.	FEB	RUARY 13,	2006
	6		mony a				N STREE	T BALTIMORE,	MARYLAND	21201
	Sta Registi		31. Date filed (Month, Day, Yelar) FEB 1 4 201	6 Serve	ar's Signature	we				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 6:45 P.M Morris Questal February 8, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery 3128 Gracefield Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 13 7 19 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1₹1M 2□ F New York 86 117-03-5236 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If tem 27 is marked other than "natural; or Items 23a or 28e-f show eny injury or other traumatic event, the Medical Exercities traust be restlifted at appear. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits . 1 1 Yes 2 □ No Maryland Montgomery Silver Spring Direct 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code United States 3128 Gracefield Road 20904 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2□No ive WW II 1 Never Married 2 Married 1X Yes 1 ☐ Yes 2√2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contract Specialist U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Usher Questal Anne Alscher ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (*Street and Number or Rural Route Number, City or Town, State, Zip Code*) 3128 Gracefield Road, Silver Spring, MD 20904 Julia Questal/ Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Geography crematory or other place) Medical Center 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 Donation 5 Other (Specify) 21. S'anature qu Funer | Service Lice : e 22. Name and Address of FacilityColumbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037 Fift. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) year Physician End /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physiclan Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 Z No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death Check only one examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how intury occurred 28c. Injury at Work? Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

or Attending Physician: within 24 hours after deatl To the Funeral Director:

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) 10 2006

(Check only

29b. Signature and title of certifier

Loveen



rushuma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D59524

29d. Date signed (Month, Day, Year)

na,MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Feb. **Physician** 9, Kermit K. Reeder 8:48 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) Apr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr. | 4 Pr Frederick Memorial Hospital Frederick 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**X** M 2 □ F 219-34-5743 69 Director 1936 MD Usual Residence of Decedent the Maryland woye 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at MD Frederick Buckeystown Director 1 XYes 2 No 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2550B Buckeystown Pike 21710 USA or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 195 XIXYes 2 \(\text{No.}\) No If Yes, Give Year or Dates: 196 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1958-72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 1962 δ Specify: White 3 Widowed XXDivorced nature Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "eny injury or other traumatic event, Ita Mea. 2008. Elementary/Secondary (0-12) College (1-4or 5+) 10 carpenter construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Melvin R. Reeder Eva R. Koogle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Reeder (Son) 101 Dogwood Dr., Hurlock, MD 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery2/13/06 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) Thre of Funeral Service Licens Donald dodges of Thompson Funeral Home Med 31 E. main St., Middletown, MD 21769 Part1. Enter the disease, or complications that he sed the death. shock, or heart lailure. List only one cause or e. ch line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humal transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes Division of Vital 2 No 25. Was case relerred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Depatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D17549 2/14/06 HIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. William Harper 180 Thomas Johnson Dr., Frederick, MD 31. Date liled (Month, Day, Year) 32. Resstrar's Signature State FEB 14 2006 Registrar

Months

Silver Spring

10f. Zip Code

1 ☐ Yes 2 ☐ No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Events Planner

4b. City, Town, or Location of Death

Silver Spring

20910

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NOV . 25 , 1956

2. Date of Death

feb.

18. Mother's Name (First, Middle, Maiden Sumame)

Janet B. Slaughter

7, Day 2006 ar

4c. County of Death

10g. Citizen of What Country?

U.S.A.

14. Race - American Indian,

Black, White, etc.

Specify: Black

& Girls Club

Silver Spring Boys

16b. Kind of Business/Industry

MONTGOMERY

3. Time of Death

4:30 P M

9. Birthplace (State or Foreign

Wash. DC

10d. Inside City Limits

1X Nes 2 No

	/Medic			TERRI	L
	Examin		4a, Facility Name	(If not institution	, give
	aaiiiii		Holy	Cross	Но
	Funeral		5. Social Security	Number	6. Se
	Director		579-76	-3063	1
	D		Usual Residence	of Decedent	
	ylan		10a. State	10b. County	
	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. mportant: if item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic event, the Mudical Exercities must be notified at once.	ctor	MD	Mon	tg
	# # E	ë	10e. Street and N	lumber	
	th wil	a	8560	Secon	.d
	dea g	Je	11. Marital Status		
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3	ours a	l by	3 ☐ Widowed	4 ☐ Divorced	
7	"natu	etec	(Sp	15. Deceden ecify only highe:	t's Ed st gra
Baltimore, Maryland 21215-0036	a within 72 hours after death biene. piene. Ir than "nature!; or items 23. the Medical Exacilizer must	To Be Completed by Funeral Director	Elementary/Sec	condary (0-12)	
0	Hygi Hygi Sther Int.	ပိ	17. Father's Name	e (First, Middle,	Last)
<u>a</u>	ic ev	0 8	Wal	ter J.	R
چ	shou nd N men	-	19a. Informant's	Name/Relations	hip (7
ž	od 2 27 is		Karen	Revis	(
ည်	T He of to		20a. Method of D		
Ē	permit. Pages 1 end 2 should be filed with Department of Heelth and Mental Hygiene, important: if item 27 is marked other than any injury or other traumatic event, than once.		1 ☐ Burial :	2√2 remation 1 5 ☐ Other (S	
듩	Departm Departm mporta eny inju		21. Signature of I	Funeral Service	Licen
ă	e de la companya de l		Ste	orge	1
			23a. Part1. Enter shock, or he	r the disease, or	comp
	Physician		Immediate Cause	e (Final	Jy
	/Medical		disease or condit resulting in death	1)	-
	Examiner				•
		-	Sequentially list of	conditions,	ı
	ed sit	듣	if any, leading to cause. Enter Uni Cause (Disease that initiated ever	derlying or injury	<
	and I-trar	xan	that initiated ever resulting in death	nts ' ı) Last	1
က္က	cien cien ouria	<u>=</u>			ı
8	sate shysi	음			
Box 68/6	I the death certificate be executed by the attending physicien and eched for use as the burial-transit	hysician/Medical Examiner	IF FEMALE:		
õ	tend tend	an	23b. Was decede in the past 1		
0.	des de fc	S	1 ☐ Yes 2	2 ☑ No	
9	t the by th	Ę.	9 Unknow	vn	

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

TERRI

Facility Name (If not institution, give street and number)

Holy Cross Hospital

LYNN

1 ☐ M 2 🔂 F

6. Sex

Montgomery

8560 Second Avenue, #1508

15. Decedent's Education (Specify only highest grade completed)

REVIS

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give

College (1-4or 5+)

2 yrs

If Yes, One Year or Dates:

7. Age (In yrs. last birthday)

49

Yrs.

10c. City, Town or Location

Walter J. F	Revis				and the same of th	Jar	net	В.	Slaı	ughter		
19a. Informant's Name/Relationship (•							or Town, State,		
Karen Revis ((Sister)	(533 Te	enth	St,	#6,	\mathtt{Br}	ookl	yn I	NY 112	15	
20a. Method of Disposition 1 ☐ Burial 2√2 Premation 3 ☐	Removal from State	cem	e of Disposition of D	ory or other	r place)	7 2-0	Date			ocation - City of		Δ
4 □ Donation 5 □ Other (Specifi	1	Me C									•	
21. Signalure of Funeral Service Licer	SMI	rle	22. N	6 N.	Wash	acility ST	t.,	Roc	kvi.	ERAL H lle, M	D 208	50
23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	ne death.	not enter t	the mode o	of dying, suc	h as cardi	ac or re	espiratory a	arrest,		Approxim Interval B	etween
Immediate Cause (Final disease or condition resulting in death)	a. Hepat	ic 1	Failu	re							1 We	
resulting in assum,	Due to (or as a				_						2	. 4 1
Sequentially list conditions, if any, leading to immediate	b. Metas Due to (or as a c		ic Bre	east	Cano	er				_	2 mo:	ntns
cause. Enter Underlying Cause (Disease or injury			,-									
that initiated events resulting in death) Last	CDue to (or as a c	consequer	nce of):									
	d											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	☐ Fetal de	ath 3⊟Ed	ctopic preg ther (spec						23d. Date of de Month	elivery Day	Year
Part II. Other significant conditions of	ontributing to death but	not resulti	ng in the unde	erlying cau	se given in F	Part I.		23e. Did	tobacco	use contribute I	lo the cause o	f death?
							_	10	Yes 2	X ∑X 0 0 3 ☐ P	robably 4 [Unknown
								24a. Was	s an	24b. Were a	utopsy finding	s available
								auto perf 1 Yes	ormed? 2½ No	death?	completion of s 2 □ No	cause of
25. Was case referred to medical examiner?					· · · · · · · · · · · · · · · · · · ·			Check only				
1 ☐ Yes 230 No	Hospital: 1 Inpatient	2 🗆 EF	VOutpatient	3□ DOA	Other: 4[Nursing	Home	5 ☐ Res	idence	6 ☐Other (Sp	ecity)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day)	(ear)	Bb. Time of Injury	280 M	Injury at Work?		280	d. Describe	how inju	ry occurred		
3 Suicide 6 Could not be determined		/ - At home (Specify)	e, farm, street	, factory, o	ffice		28f	Location City or To		nd Number or R e)	Rural Route No	ımber,
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of niner: On the basis of ea and manner state	xamination	edge, death o	ccurred at stigation, in	the time, da	te and pla- , death oc	ce, and	d due to the at the time	cause(s , date an	and manner a d place, and du	is stated. e to the cause	n(s)
29b. Signature and title of certifier				29c. l	icense num	ber			29d. Da	ate signed (Mon	th, Day, Year)	
find. M.	Sundl	mo		Adama and a second	D3599	96			Fe	b. 8,	2006	
30. Name and address of person who Linda M. Bu:			3a) (Type, Pri	nt) Univ	ersit	tv B	lve	#4	00.	Wheato	2090 n, MD	2
31. Date filed (Month, Day, Year)	32 Aegistrar					-1 -		- " -	/			
31. Date filed (Mortin, Day, 19ar)	J JZ megistrar	s signallyr		40 0								

DHMH 17 Rev 1/2001

State

Registrar

FEB 10 2006

Division of Vital Records.

Hospital or Attending Physician:

			For State Registrar		State of Ma	ryland /		rtment of ificate o	Health and M	-	giene Reg. No. 0 0 6	05979
1	Dhusisi		1. Decedent's Name (Fil	rst, Middle, Last)	0					2. Date of De Month	ath Day Yea	3. Time of Death
	Physici /Medic		DAIT	-	KO515	>				02	11 0	6 0925 M
	Examin	er	4a. Facility Name (If not	institution, give s	treet and number)	T 1		4b. City, Town	, or Location of Death		4c. County of D	eath
		- (gr -a	CASTAL		PICE AT	WE L	AKE		LISBURY			MICO
	Funeral		5. Social Security Numb		7. Age	(In yrs. last	Yrs.	If Under 1 Yes Months Day		8. Date of Bird (Month, Da	th y, Year) 9.1	Birthplace (State or Foreign Country)
100	Director	-	123-26-7 Usual Residence of Dec	146		1/	113.			3-5	-34	NY
	land m			. County		10c. City, To	own or Loc	ation				10d. Inside City Limits
	Mary Figh	tor	MA	11/1805	nico	S	All	SBURY				1 Yes 2 □ No
	ith the Marylar or 28a-f show se notified at	rec	10e. Sireet and Number	(110-0	10f. Zip Code	9		10g. Citizen of Whal	Country?
	3a o	Funeral Director	405F 7	BROOKE	RIDGE !)a		2	1804		115A	
	deat	ner	11. Marital Status		12. Was Decedent Ev Armed Forces?	er in U.S.	13. W		of Hispanic Origin? (Sp. uban, Mexican, Puerto	ecify Yes or No	- 14. Race - A	merican Indian,
9	or ite	3	1 Never Married		1 Yes 27 No			Yes 2 N		rticari, otc.)	Specify:	/hile, etc.
93	urali,	d by	3 Widowed 4 🗆	Divorced	Year or Dates:						ореспу.	BLACK
215-0036	filed within 72 hours after death with the Maryland Hyglene. ther then "natural", or fleme 23a or 28e-f show thit, the Medical Examinar must be rotified at	Completed		Decedenl's Edu- nly highest grade		11	(Give k	ent's Usual Occ ind of work do O NOT use ret	ne durina most of work	ing	16b. Kind of Busine	ess/Industry
12	withir ane.	du	Elementary/Secondar	y (0-12)	College (1-4or 5+)		-			Toda II.	Tarren
d 21	Hygie ther ther		17. Father's Name (First	t, Middle, Last)			170	LA D	18. Mother's Name	e (First, Middle,	Maiden Sumame)	EL TRUCKING
an	Mental Mental arked o	э Ве	Januar	Ras	. P				VIRGIN	VIA C	NY	
Maryland	2 should and Men ie marke aumatic	으	19a, Informant's Name/	Relationship (Tv	pe, Print)	1	9b. Mailing	Address (Stre	eet and Number or Run		er. City or Town. Stat	e. Zip Code)
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ē	s 1 and 2 f Health itsm 27 other tr	,	20a. Method of Dispositi			20b. Place	of Dispos	ition (Name of atory or other p		Date	20c. Location City	or Town, State
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Baltimore,	그 문문을 .		21. Signature of Funera	I Service License	98	O.C.	22.	Name and Add	dress of Facility Be	INNIE	SMITH	F/4
m	Department Department		Mus	ulla	Kouna	W	9	12.W.I	SABELLAS	ST. SAL		ND. 21801
			23a. Part1. Enter the di shock, or heart fail	sease, or compli lure. List only or	cations that caused the cause on each line	he death. [o not ente	the mode of o	tying, such as cardiac	or respiratory ai	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Fina disease or condition	1	60	NG	- 0	AN C	ER.			Onset and Death
	/Medical Examiner		resulting in death)	(Due to (or as a	consequen	ce of):	- > •	2			
	LAGITITIE		Sequentially list condition	ons, b				DNI	H ·			
	bed is	ine	if any, leading to immed cause. Enter Underlying Cause (Disease or injur	g 4	Due to (or as a	consequen	ce or).					
_	xecut and II-tran	Examiner	that initiated events resulting in death) Last	' ·	Due to (or as a	consequen	ce of):					
8760	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	calE										
687	ficate physis the											
XO	death certifica attending ph of for use as the	N/	IF FEMALE: 23b. Was decedent pre-	gnant 2	3c. If yes, outcome of						23d. Date of	delivery
B.	death e atte d for	icla	in the past 12 mon 1 ☐ Yes 2 No	ths?	1 Live birth 2 4 Pregnant at ti			Ectopic prøgna: Other (s <i>pecify)</i>			Month	Day Year
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ď.	res thai igned t be det	ру Р	Part II. Other significan	t conditions cor	tributing to death but	not resultin	g in the und	derlying cause	given in Part I.	23e. Did 1	obacco use contribut	e to the cause of death?
ord	w require been sig	ed								1,5%	Yes 2□No 3□] Probably 4 Unknown
Records,	as be	Completed								24a. Was		autopsy findings available to completion of cause of
<u> </u>		Con								perfo 1 ☐ Yes	rmed? death	n?
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to examiner?						26. Place of Deat	h Check only o	one)	
of/	hysi this c	은	1 □ Yes 2 No	1	ospital: 1 Inpatient		Outpatient	JU DON			dence 6 Other (S	Specify)
n c	ding Phys	on:	27. Manner of Death	Pending	28a. Date of Injury (Month, Day	Year) 28	b. Time of Injury		Vork?	28d. Describe i	how injury occurred	
Sic	Attending or death. ector: After by the fune	icat	2 Accident 3 Suicide 6	investigation ☐ Could not be	28e. Place of Injur	v - At home	farm elro		☐Yes 2☐No	28f Location (Street and Number of	r Rural Route Number,
Division	after Direction by	Certification:	4 ☐ Homicide	determined	building, elc.	(Specify)	, iaiiii, sile	et, factory, offic		City or To		Harai Houte Hamber,
	spitel cours neral		29a. Certifier 1	Certifying Phys	sician: To the best of	my knowled	dge, death	occurred at the	time, date and place,	and due to the	cause(s) and manner	r as stated.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 none)	Medical Examin	ner: On the basis of e and manner state	xamination	and/or inve	stigation, in m	y opinion, death occur	red at the time,	date and place, and	due to the cause(s)
	withir To the	ž	29b. Signature and title	of certifier	0				ense number		29d. Date signed (M	1
)	63		Laure	ee h	1 (50	ace		17	14256		2/11	106.
	12			of person who co	mpleted cause of dea	ath (Item 23	a) (Type, P	rint) COS				ELAKE
	4)		YMMES		SAACS	17E	1525	HEAT	> SALIS	BUR	y MID	2180/-
	Sta Registi	7	31. Date filed (Month, D	*	32. Registrar	's Signature) }	0			,	,
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Physician	Decedent's Name (First, Middle,	,	a 1		2. Date of Deat Month	h Day	Year	3. Time of Death
/Medical		is Rosales	Sanchez		FEB. 6	2006		0641 A '
Examiner	4a. Facility Name (If not institution, NORTHBOUND 205	give street and number)	4b. City, Town, or WALDOR	Location of Death		4c. County CHAR		
Funeral Director	5. Social Security Number none	7. Age (In yrs. Ia:	st birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/27/	^{Year)} 1974	9. Birthpla Count Hone	ace (State or Foreig V) duras
D S	Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Location				40	d taild On an a
within 72 hours after death with the Maryland then "naturel", or items 23s or 28s-1 show he Mudical Examiner must be notified at hompleted by Funeral Director	MD Princ		amp Springs				10	d. Inside City Limit 1 ☐ Yes 2 ☐ N
s or 28a-f a be notified Director	10e. Street and Number		10f. Zip Code		10	Og. Citizen of V	Vhat Count	v?
23a o sat be	5216 Moeeis A	venue Apt.20	08 2074	6		Hon	dura	Ś
iene. rthen "naturel", or Items 23a or 28a-f ahow the Medical Examinar must be notified at ompleted by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, e	
i, or l	1 Never Married 2 Marne 3 Widowed 4 Divorced	d 1 ∐Yes 2 M2No If Yes, Give Year or Dates:	15 Yes 2 No	Specify:		Specify		ite
ted t	15. Decedent's	Education	16a. Decedent's Usual Occupa	Hondur		16b. Kind of Bu		
t, the Medical E	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	luring most of worki	ing			•
Correction Correction	1		Carpenter			Const		ion
ked other ic event, ii	17. Father's Name (First, Middle, L. Segundo De Je	•		18. Mother's Name	o (First, Middle, M Omasa S			
marke matic	19a. Informant's Name/Relationshi		19b. Mailing Address (Street a					On do)
27 is my	Jose Rosales,		3826 Milan	Road Al	exandri	ia, Va.	2230	5
item 27 is marked to the traumatic	20a. Method of Disposition	1	ce of Disposition (Name of netery, crematory or other place	1 0	Date 2	Oc. Location -	City or Tow	n, State
= =====================================	1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Ingrioval from State /	.Las Canita	š 2/15,	/06	Olancl	no, Ho	onduras
Important: # ite any injury or of once.	21. Signature a Funeral Service Li	colsio (i)	22. Name and Addres	s of Facility			D 3	
E 5 8	Myz	Walk'	PHILIP D. I 9241 Columb	ia Blvd.S	ilver Sr	ring	,Р.А. Md 20	910
		omplications that caused the death. Ity one cause on each line.	Do not enter the mode of dying	g, such as cardiac o	or respiratory arre	st,	í	Approximate nterval Between Onset and Death
ician dical	Immediate Cause (Final disease or condition resulting in death)	- head and	. Chest ini	wies				Onset and Death
niner	researing in deapty	Due to (or as a conseque	nce of):					
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ding p	IF FEMALE:	23c. If yes, outcome of pregnance				1		
atten I for u	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deal	eath 3 Ectopic pregnancy			23d. Date Mon	of delivery oth D	ay Year
by the	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
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should the					1 🗆 Yes	2 X No	3 ☐ Probat	oly 4 Unknow
page 2 should					24a. Was an autopsy	24b. W	ere autops	y findings available
cate has page 2 c					perform 12 Yes 2	ed? d	eath?	□No
rector, pag	25. Was case referred to medical examiner?	Hospital:	VOutpatient 3F DOA Othe	26. Place of Death				
a P	No 27. Manner of Death	28a. Date of Injury 28		TO THE SING THE	ne 5 ☐ Resider 28d. Describe hoy			AT SCENE
al Director: Atter ed in by the funera Certification;	1 □Natural 5 □ Pending 2 ☑ Accident investiga	ion A - (a - O 6	3b. Time of 28c. Injury Work	? es 2 No	erected	- mato	revi	ichle
by th	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	be con Diana of lains Athen	e, farm, street, factory, office	2	81. Location (Stre	et and Numbe		Route Number,
Cer	() ————————————————————————————————————	Sunding, etc. (Specify)	Keet		No City or Town.	300 3	2	
To the Funeral Director: A completely filled in by the fu	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best of my knowle aminer: On the basis of examination	edge, death occurred at the time and/or investigation, in my op	e, date and place, a inion, death occurre	and due to the car	ico(c) and mar	ner as stat	ed. ne cause(s)
o the	29b. Signature and title of certifier	and manner stated.	29c. License			d. Date signed		
⊢ ŏ	Mater !	100 cm 1 - POOL	3 4	M.E.		FEB. 6,	-	
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	wince 100	Orena					
	30 Name and address of person wi	o completed cause of death (Item 2	3a) (Type, Print)					
	Vala: 15	() ()	3a) (Type, Print) 1 PENN STREET,	BALTIMO	RE,MARYL	AND 212	201	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Barbara Donahue Sweeney February 9, /Medical 2006 3:35pm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🖺 F Director 392-22-8432 79 Nov. 5, 1926 Wisconsin Usual Residence of Decedent the Maryland or 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2K No Directo Maryland Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural", or itema 23a or 3 and injury or other treumatic event, Ira Madical Exemples from an once. 415 Christopher Avenue #31 20879 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 257 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No δ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 John Francis Donahue Stella Bjorklund 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Christopher Avenue #31, Gaithersburg, MD 20879 John Joseph Sweeney (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State plitan Crematory 2/10/06 Alexandri.
22. Name and Address of Facility DeVol Funeral Home
10 East Deer Park Drive
Gaithersburg, MD 20877 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signature of Euneral Service Licen over Hart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 0 **Physician** 2 D , Va 101U /Medical Due to (or as a consequence of) Examiner Luce 2 MADRIC 07 ulmonay Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician end for use as the burial-transit The law requires that the death certificate be executed cobackrium avium intrace Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached to 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Risa Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 🔀 No 1 Yes 2X No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 1 3 Inhatient 2 ER/Outpatient 3□ DOA After thi funeral 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Watural 5 Pending investigation death. 1 ☐Yes 2 ☐ No within 24 hours after death To the Funerel Director: / completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 1

00054068

Shady Grove

2006

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			1 - For State Registrar		Maryland /	Departn		lealth and) 6	05982
	Physic	ian	Decedent's Name (First, Middle						2. Date of De Month	ath Day	Von	3. Time of Death
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	Exami	ner	4a. Facility Name (If not institution			4b.	City, Town, o	r Location of Dea	th	4c. Count	y of Death)
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	Funeral		5. Social Security Number		Age (In yrs. last b		Inder 1 Year onths Days	If Under 24 Hrs Hours Min.		th	9. Birth	place (State or Foreign
	Director		578-01-2065	1 XM 2 ☐ F	96	Yrs.	Juy 5	Tiodio Iviii	JAN. 6			DIANA
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	or Location						
	Aaryl • • ho	ō			iou. Oity, 100							10d. Inside City Limits
	the N	ect	MD. MONTGO	MERY				SPRING				1 X Yes 2 ☐ No
	with	Funeral Director		n nn		10	f. Zip Code			10g. Citizen of	What Cou	intry?
	eath	era	121 EASTMOO					20901			5.A.	
	Iten d	Ë	11. Marital Status	12. Was Decede Armed Force	s?	13. Was E	Decedent of Hi specify Cuba	ispanic Origin? (S ın, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Ra Bla	ce - Ameri ick, White,	can Indian, etc.
336	urs af	by	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 TYes 2[If Yes, Give Year or Date	T.T.T.T	1 🗆 Y	es 25 No	Specify:		Speci	fy:	
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2121	d within giene. r than "	Eo	Elementary/Secondary (0-12)	College (1-4d	or 5+)		ANAGER			MELIC	S SER	VICE
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a	lid be fental rked o	ToB	GEORGE	L. SPA	NN				KATIE	KLEI	,	
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exertal artificial to the configuration of the confidence of	-	19a. Informant's Name/Relationsh	ip (Type, Print)	198	o. Mailing Add	iress (Street a		ıral Route Numbe			2 Codel
	and 2 Balth a n 27 is		WILLIAM C. SP	ANN/SON					. #103,			
re	Tan and		20a. Method of Disposition		20b. Place of	f Disposition	(Name of or other place		Date	20c. Location		
Baltimore,	permit. Pages Department of Important: If its		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ☐Removal from Stare ecity)	10		REMATO	· 1	2006	DIMEDE		· · ·
aĦ	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service L	igensee /						RIVERD	ALE,	<u>м</u> и.
Ω	99 - 9		11/11/11/11/Ch	ambus	M0009	CHAM 1 5801	BERS FI	UNERAL H LAND AVE	OME & CR	EMATORI	UM, P	.A.
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caus	ed the deeth. Do	not enter the	mode of dying	g, such as cardiad	or respiratory an	rest,	ιμ. Ζ(Approximate
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45	Examiner		0	Myo	cardial	Info	arctio	Sh				1 week
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	nd rans	Examine	that initiated events	. Acut	e Ker	ial F	gilur	と				30945
Ö,	s be executed sician and burial-transit		resulting in death) Last		s a consequence							
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9	eath certific attending pl	Mec	IF FEMALE:									
Вох	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	e of pregnancy 2 Fetal death	3∏Ecton	ic pregnancy			23d. Da	te of delive	ory
<u>.</u>	the a	SIC	1 Yes 2 No		at time of death	5 Other				Mo	nth	Day Year
P.O.	that the de ned by the a detached f	Phy										
Š	ires t signe l be d	þ	Part II. Other significant condition	s contributing to death	but not resulting in	the underlyi	ng cause give	n in Part I.				e cause of death?
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Zi Zi	iician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?					26. Place of Deat	h (Check only on			
of	Shys this c	ဥ	↑ Yes 2 No		ient 2 ER/Ou	tpatient 3	DOA Other	t. 4 🗆 Nursing Ho	ome 5 🗆 Reside	ence 6 Oth	er (Specify)
L C	fing l	lon	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, D		ime of njury	28c. Injury Work?	at ?	28d. Describe ho	w injury occurr	ed	
Sic	death death ttor: the	cat	2 Accident investigat 3 Suicide 6 Could no	t be		M		es 2 No				
<u>></u>	or A after Direction by	Certification:	4 Homicide determine	ed 28e. Place of Ir	itc. (Specify)	rm, street, fac	tory, office		28f. Location (St City or Town	reet and Number, State)	er or Rural	Route Number,
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page		29a. Certifier 12 Certifying	Physician To the h	l of much series							
:	24 h	edical	(Check only one)	Physician: To the bes miner: On the basis and manner s		, death occur Vor investigat	red at the time tion, in my opi	e, date and place, nion, death occur	and due to the cared at the time, do	ause(s) and ma ate and place, a	nner as sta	ated. the cause(s)
	o thi o the omple	-	29b Signature and title of certified	C Case	<u></u>		20- 1:					
			1	5	1->	T 110	7	60359	2	9d. Date signed	(MONTA, L	February 6 9,2006
C	1+1	-	30. Name and address of person wh	SEAV S	> >MED	LMU		7		4/7/6	00	019,2006
			Sean S Saedi,	SEAN SEAN SEAN SEAN SEAN SEAN SEAN SEAN	New Ho	Type, Print)	ire A	venue. S	gite 30:	3, Silve	· Spri	ing, MD
Jay 3	Sta	e	31. Date filed (Month, Day, Year)	32. Regist	rar's Signatyre	1	1					20904
1	Registr	100		2006	16	AND THE						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Frances Sherman February 10, 2006 5:12 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Collingwood Nursing Home Rockville Montgomery 8. Date of Birth (Month, Day, Year)
Nov. 14, 1916

9. Birthplace (State or Foreign Country)
Washington, D.C 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 6. Sex **Funeral** Days Hours 1 ☐ M 2 ☐ F Director 89 213-50-6622 Usual Residence of Decedent the Maryland 10c. City, Town or Location אפוני: וו ונפות בכי ופ marked other than "natural", or Items 23a or 28a-1 ehow ility of other traumatic event, וויש Medical Examinat must ke notified at 10a, State 10b. County 10d. Inside City Limits 1 XYes 2 No Maryland Montgomery N. Bethesda Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5550 Tuckerman Lane 20852 U. S. A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or having injury of Other traumatic. Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 **X** No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ vidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 Years Retail Clothing/Jewelry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Abe Rappaport Jennie Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Sherman - Son 13324 Dauphine Street, Silver Spring, Maryland 20906 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Gdns 2/13/2006 Falls Church, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc. Donald 1091 Rockville Pike, Rockville, Maryland _20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician ar Due to (or as a consequence of): Box 68760 Physician/Medical as attending p IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 🗆 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy page nerform certificate 1 Yes 1 🗌 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending after death.

Director: Af investigation 1 Yes 2 No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier npletely (Check only one 29b. Signature and title of contified 29d. Date signed (Month, Day, Year) D0062435 completed cause of death (Item 23a) (Type, Print) Day, Year) 32 Registrar's Signature State 13 2006 Registrar

			1 - For State Registrar	State of M	larylan		artment rtificate			and M	lental H	lygie Reg	601	16	05	984
	Disconing		1. Decedent's Name (First, Middle, Las	t)							2. Date of Month		Day	Year	3. Time o	of Death
	Physici /Medio		Frances P. Smith									2/1	0/200		11:	15P [™]
J.	Examin	er	4a. Facility Name (If not institution, give						Location o	of Death		•	4c. County	of Death		
			Berlin Nursing & R 5. Social Security Number 6. Se				Berl If Under 1		If Under 2	24 Hrs. i	0.5	2:45	Worce			
	Funeral Director			" ⊐м Ж ДГ /. А	90 (in yrs. i 90	a <i>st birthday)</i> Yrs.		Days	Hours	Min.	8. Date of 1 (Month, 08/10/	Day, Y	ear)	9. Birth Cou	place (State ntry)	or Foreign
			Usual Residence of Decedent					1		!	00/10/	191	3		PA	
	nylan ihow	_	10a. State 10b. County		10c. City	, Town or Lo	cation								10d. Inside C	*
	Ba-f s	cto	MD Worcest	er	0ce	an Pin	es								1 🗌 Yes	₹XX No
	vith th	Director	10e. Street and Number				10f. Zip (Code				10g	. Citizen of V	What Cou	ntry?	
	e 23g	eral	5 N. Pintail Driv	/e 12. Was Decedent	Free in 11:	C 12.1		1811		-:-2 (0	-4 V		USA		and the	
40	iter d	by Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces	?	'			n, Mexican	gin? (Spe i, Puerto	ecify Yes or Rican, etc.)	NO-		e - Amen k, White,	can Indian, etc.	
036	ursal	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□ Yes 2	χχνο	Specify:				Specify	· Whi	ite	
2	within 72 hours after death with the Maryland ene. than "natural", or iteme 23s or 28s-f show than "mailter notified at	Completed	15. Decedent's Edi (Specify only highest grad			16a. Deced	lent's Usual	Occupa	tion	t of works		16	b. Kind of Bu	ısiness/Ir	ndustry	
7	ithin Ma	nple	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work DO NOT use	e retired)	unig mosi	OF WORK	ig					
2	filed w Hygier other th		17. Father's Name (First, Middle, Last)			Home	maker		40.14-4-	1- 11-	/F:		wn Hon			
anc	t be find he of ot	Be											iden Sumam	10)		
Ž	should be and Mental s marked o umatic eve	2	Gregory Procopio 19a. Informant's Name/Relationship (T	vne Print)		19h Mailir	a Address /	(Street a			Stenn		a tity or Town,	State Zi	Codel	
\mathbf{z}	and 2 sealth arm 27 is ner treu		Phyllis Leonardo(c										MD 218		0000)	
ē,	一工意義		20a. Method of Disposition			lace of Dispo	sition (Name	e of		Ceal	ate	20	c. Location -	City or T	own, State	
Baltimore, Maryland 21215-0036	permit. Pages Department of i Importent: If It eny injury or o		XX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,		F 1	dowrid	-			2/15	/2006	F	lknida	o M	D	
a	permit. Departn Importe eny inju		21. Signature of Funeral Service Licens	600		22	. Name and	Address	of Facility	y Bur	bage	Fune	eral Ĥ	ome		
<u> </u>	8988		/ Pacquelero	1 Day	but								4D 218	11		
ı			23a. Part1. Enter the disease, or composhock, or heart failure. List only of	lications that cause ne cause on each	ine.	. Do not ent	er the mode	of dying	, such as o	cardiac o	r respiratory	arrest			Approxima Interval Be	tween
7	Physician		Immediate Cause (Final disease or condition	_{a.} Ather	roscle	erotic	Cardi	ovas	scula	r Di	sease				Onset and Years	Death
П	/Medical Examiner		resulting in death)	Due to (or as												
		-	Sequentially list conditions,	b. Type I										у	ears	
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
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89	ng ph	Med	IF FEMALE:													
Вох	leath certifica ettending pt I for use as ti	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal	death 3	Ectopic pre						23d. Dat	e of delive	*	Year
0	e ett e ett hed f	ysic	1 ☐ Yes 2/□ No 9 ☐ Unknown	4□ Pregnant a 9□ Unknown	t time of de	ath 5⊡	Other (spe	city)					14101	iui i	Day	i oai
o.	The law requires that the death certific te has been signed by the ettending p bage 2 should be detached for use as		Part II. Other significant conditions co	ntributing to death t	out not resu	Iting in the ur	iderlying car	use giver	n in Part I.		23e. Did	tobac	co use contr	ribute to t	he cause of	death?
Ś	ures sign ld be	Completed by	Chronic Renal In				, ,							3 🗆 Prot		Uлknown
Ş	w requir	lete								_	24a. W	as an	24b. V	Vere auto	psy findings	available
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<u>ra</u>	ian: rtifica stor, p	BeC	25. Was case referred to medical						26. Place	of Death	(Check only		Wo i	Yes	2 NO	
<u>></u>	Physician: The lav this certificate has ral director, page 2	10	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 ☐ Inpati	ent 2 🗆 E	ER/Outpatien	3 DOA	Other	· XIX Nur	rsing Hon	ne 5 ☐ Re	sidenc	e 6 □Othe	er (Specif	ý)	
ב ס	Ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry ıy Year)	28b. Time of Injury		c. Injury	at ?	2	8d. Describ	e how	injury occurr	ed		
Sio	tendi Jeath tor: A the fi	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				М		es 2 N							
Division of Vital Records, P.O.	spital or Attending ours after death. erel Director: After filled in by the funet	Certification:	4 Homicide determined	28e. Place of In building, e	tc. (Specify	me, tarm, stre	eet, factory,	office		2	City or 7	(Stree own, S	t and Numbe tate)	er or Rure	al Route Nun	nber,
	spital ours ours nerel filled		29a. Certifier XXCertifying Phy	sician: To the best	of my know	vledge death	occurred at	t the time	date and	1 place a	and due to th	9 (3116	e(s) and ma	ADOL SC C	tated	
	To the Hospital or Attending Physician: within 24 hours alter deals as the feature. To the Funerel Director: After this certified completely filled in by the funeral director; to	edical	(Check only 2 Medical Exami	ner: On the basis of and manner st	ot examinati	ion and/or inv	estigation, i	n my opi	nion, deat	h occurre	d at the time	e, date	and place, a	and due to	the cause	s)
	vithir To th comp	Me	29b. Signature and title of certifier		,		29c.	License	number			29d.	Date signed	(Month,	Day, Year)	
			Y BA	rul	-	رسط	D2	28769	9			02	2/13/2	006		
	S- 1		30. Name and address of person who co	•	-		,									
	53		Nicholas Boroduli 31. Date filed (Month, Day, Year)	a, MD 120	9 Coa	astal	Hwy. F	enw	ick I	slan	d, DE	199	944			
	Sta Registr		FEB 1 4 2	006	ur s signat	b A	note.									

			1 - For State Registrar	State of M	arylar		artment of F tificate of			_	ene No.	6	05985
	Physici	an	1. Decedent's Name (First, Middle	-						Date of Death Month	Day	Year	3. Time of Death
	/Media	cal	Jack A. S 4a. Facility Name (If not institution,	olomon						bruary	11, 20	006	1:26 p. M
	Examir	ier	7703 Bridle Pa		,		4b. City, Town, o		of Death		4c. County	of Death ederi	
	Funeral			6. Sex 7. Ag	ge (In yrs.	last birthday)	If Under 1 Year	If Under 2		Date of Birth		9. Birth	place (State or Foreign
	Director		232-42-8797	1 m M 2 □ F	74	Yrs.	Months Days	Hours		Month, Day, Y an. 25,			t Virginia
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Mary a-f sh	tor	Maryland Freder	ick	Fı	rederic	k						1 ☐ Yes 2 🛣 No
	ith the	Director	10e. Street and Number				10f. Zip Code			10g	. Citizen of V	What Cou	ntry?
	s 23a		7703 Bridle Pat				217					SA	
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Itams 23a or 28a-1 show imatic avant, the Modical Examirer must be notified at	by Funerai	Marital Status Never Married 2 Marrie Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 1 2 Yes 2 1 ! Yes, Give Year or Dates:	?	1	Vas Decedent of H f Yes, specify Cub □ Yes 2▼ No	dispanic Orig an, Mexican Specify:	gin? (Specify n, Puerto Rica	Yes or No- in, etc.)	Blac	e - Ameri k, White, /: Wh i	
2-0036	2 hou	ted	15. Decedent	s Education		16a. Deced	ent's Usual Occup	oation		16	b. Kind of Bu	usiness/In	dustry
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anc	d be fi) Be	_	•	C - 1					rst, Middle, Ma			
Maryland 2121	es 1 and 2 should to of Health and Ment item 27 Is marked rother traumatics	2	Sam 19a. Informant's Name/Relationsh		So1or		g Address (Street	Mauc and Number		ute Number, C	Sla		o Code)
	and 2 ealth a n 27 Is		Rosemary Solomo	n/Wife		1.	3 Bridle						
altimore,	es 1 a of He fitam r oths		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation	3 □ Bomouni from State		Place of Dispos semetery, cren	sition (Name of natory or other place	ce)	Date	20	c. Location -	City or To	own, State
Ě	. Pages tment of l tant: If it jury or o		`4 □ Donation 5 □ Other (Sp	ecify)			n Mem. G				ederi		
g	permit. Pages 1 Department of H Important: If ital any injury or ott		21. Signature of Funeral Service L	ulle M	ine	_ 16	Name and Addre	umtowi	n Pike	, Frede	rick,		
	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition	only one cause on each II	d the deat ine.		er the mode of dyir						Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):				5			
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	cuted id ansit	Examiner	Cause (Disease or injury that initiated events										
Ď,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as	a conseq	uence of):							
8/PD	cate b	dicai		d								-	
DOX D	certifi nding use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	incy					23d Dat	e of delive	20/
ă	death e atter	iciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnancy Other (specify)	/		·	Mor		Day Year
<u>т</u> Э	at the by th	hys	9 Unknown	9□ Unknown									
Records, I	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		Part II. Other significant condition	is contributing to death b	out not res	ulting in the un	derlying cause giv	ren in Part I.	_	- 4			he cause of death? pably 4 Dunknown
	> 4	ompieted	Hypertens	100	· · · · ·					24a. Was an autopsy performed	1? g	rior to co leath?	psy findings available mpletion of cause of
VII		e C	25. Was case referred to medical					26 Place		1 Yes 2	No 1	Yes	2□ No
		ToB	examiner? 1 ☐ Yes 2 █ No	Hospital: 1 Inpatie	ent 2	ER/Outpatient	3□ DOA Oth			Residence	e 6 □Othe	er (Specif	y)
IO LOI	ath. ath. r: After the		27. Manner of Death Natural 5 Pending 2 Accident investiga		y Year)	28b. Time of Injury	28c. Injur Wor M 1	y at	28d.	Describe how i			
DIVISION	al or Atta s after de al Diracto ed in by th	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At ho c. <i>(Specif</i>)	ome, farm, stre	et, factory, office			ocation (Stree City or Town, S		er or Rura	I Route Number,
	To the Hospital or Attanding Physwithin 24 hours attended. To the Funeral Director: After this completely filled in by the funeral di	edicai (29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best xaminer: On the basis of and manner sta	t examina	wledge, death tion and/or inv	occurred at the tinestigation, in my o	ne, date and pinion, death	d place, and o	due to the caus the time, date	e(s) and mai and place, a	nner as s	tated. the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier				29c. Licens	e number		29d.	Date signed	(Month,	Day, Year)
			m/00	W Com	2		MO	5161	0		1-/1:	3/0	6
l o	+IVA		30. Name and address of person w		-		,					7	
	Sta	te	Dr. Michael To 31. Date filed (Month, Day, Year)	1475 32. Regist	Tane r's Signa	y Ave.	Freder	ick,MD	21702	2			
豪	Registr		FEB	1 5 2006	Con	s St.	Spelle						

		1- State of Maryland / Department of Health and Certificate of Death		giene) 06	05986
Physicia	ın	Decedent's Name (First, Middle, Last) I T	2. Date of Dea Month	Day Year	3. Time of Death
/Medic Examin		Wilton O. Smith, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	February	4c. County of Deat	
		13419 Catoctin Furnace Road Thurmont 5 Social Security Number	e o Data d Dist	Frede	
Funeral Director		214-42-1462 1™ 2□F 63 Yrs. Months Days Hours Min		, Year) 9. Bin Co , 1942 Man	hplace (State or Foreign untry) ryland
land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Mary a-feh	tor	Maryland Frederick Thurmont			1 ☐ Yes 2 ☐ No
with the	i Dire	10e. Street and Number 13419 Catoctin Furnace Road 10f. Zip Code 21788		10g. Citizen of What Co	ountry?
72 hours after death with the Maryland 72 hours after death with the Maryland neture!; or Items 23a or 28a-f show deat Examiner must be notified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, specify Cuban Mexican, Pue 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No Specify:	Specify Yes or No- irto Rican, etc.)	14. Race - Ame Black, Whit Specify:	
1.00	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work done during most of work done during most of work done during most of work done	orking	16b, Kind of Business	Industry
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2 should be filed with and Mental Hygiene, ie markad other that aumatic event, Ital	Be	64.1	ame (First, Middle,		
d 2 should th and Men 7 ie marka traumatic	ဥ	Wilton O. Smith, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or P	S Sweeney		Zip Code)
5 2 ₹ Z		Lisa Spielman - Daughter 6812 Mountaindale Ros	ad, Frede	rick, Mary	Land 21702
8 4 = 0		4 Donation 5 Donat (Specify)	Date 8-2006	20c. Location - City or Thurmont,	
permit. Page Department of Importent: If any njury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility State 21. Name and Address of Facility State 22. Name and Ad			
		23a. Part 1. Enter the disease, or complications that diseased the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ac or respiratory are	rest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. dehydrotion		\	
Examiner		Due to (or as a consequence of) Tenal foul v(e)			10 days
D #	iner	Sequentially list conditions, in my leading to immand the cause. Enter Underlying Cause (Disease or injury)			2 decide
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icate be physicie s the bur	edicai	d			
		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	iverv
the death certify the attending ched for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1		Month	Day Year
gned igned	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to 'es 2 □ No 3 □ Pt	
The law requir sate has been single 2 should	Completed	_ C.H. F	24a. Was a autop perfor	sy prior to med? death?	itopsy findings available completion of cause of 2 \sum No
	Be C	25. Was case referred to medical examiner?	eath (Check only or	-	20 110
or the Hospitel or Attending Physicien: within 24 hours efter death. o the Funerel Director: After this certific ompletely filled in by the funeral director,	2			lence 6 Other (Spe	city)
To the Hospitel or Attendii within 24 hours efter death. To the Funerel Director: A completely filled in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number or Ri m, State)	ural Route Number,
ospitei c hours ef unerei D ly filled ir		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.			
the H thin 24 the Fi mplete	Medical	one) 2 medicar Examiner of medicar examiner of medicar examiner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo#1	
T X F 8		· Core A (wyn) D399:	37	2/8/0	6
4		Christine A Curley	Main St	reet, Emmit Maryland	tsburg, 21727
Sta Registra		31. Date filed (Month, Day, Year) 0 9 2006 32. Registar's Signature		-	

			1 - For State Registrar	State of Marylar		artment of I		Mental Hy	giene	05988
	Physic /Medi		1. Decedent's Name (First, Middle, Las		ی	is is a		2. Date of D Month		1.4
	Examir Funeral Director		4a. Facility Name (If not institution, give CHESTEAR) U.S. 5. Social Security Number 6. S.	e street and number) ER Ho 3 PI TAL ex 7. Age (In yrs.	(CEN)		If Under 24 Hrs	h ERTcw/ - 8. Date of Bi	4c. County of D	eath
	show ed at	'n	Usual Residence of Decedent 10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits
	with the N We or 28e-f	Director	MD KENT 10e. Street and Number 22080 JOHNSON		OCK HA	10f. Zip Code 216	6.1		10g. Citizen of What	1 Tyes 2 No
396	a within 72 hours after death with the Maryland Jione. r than "natural", or items 23e or 28e-f show the Medical Examinat must be redified at	by Funeral	11. Marital Status ↑ Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Amed Forces? 1 Ves 2 No If Yes, Give Year or Dates: 1974	- 1		Hispanic Origin? (S an, Mexican, Puer	specify Yes or N to Rican, etc.)	USA o- 14. Race - A Black, W Specify: [merican Indian, /hite, etc. BLACK
21215-0036	iene. r than	Completed	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12) 11th	lucation de completed) College (1-4or 5+)	pation during most of wo d) ER	rking	16b. Kind of Busine			
Maryland	should be filed nd Mental Hygi marked other umatic svent, I	To Be (17. Father's Name (First, Middle, Last) LUTHER SISCO,		HILDA					
	t and 2 sh Health and Sm 27 is m		19a. Informant's Name/Relationship (7 HILDA SISCO-MO'	THER	2208	O JOHN:		ROCK I	HALL, MD	21661
Baltimore,	permit, Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic 9009.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen:	Removal from State A	aron C	CHAPEL I Name and Addre	J.M. 2/: ess of Facility Ke	enneth	ROCK HAWAILEY For appolis, N	LL, MD Tuneral
I STATE OF	Physician /Medical		23a. Part 1. Enter the disease, or compensor, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	dications that caused the deat one cause on each line. a						Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a sheet) c. Due to (or as a consequence) d.	quence of):	Sjon				10 years
O. Box 6	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ul death 3□	Ectopic pregnanc; Other (specify)	,		23d. Date of Month	delivery Day Year
ords, P.	equires that en signed b	by	Part II. Other significant conditions co	heart for		derlying cause giv	ren in Part I.		_	to the cause of death? Probably 4 □Unknown
Vital Records,		Completed		/				24a. Was auto pend 1 🗆 Yes		
Division of Vita	Attending Physicien: The la r death. ector: After this certificate has by the funeral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 Nanner of Death 1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injur Wor	4 🗆 Nursing 🗆	ome 5 🗆 Resi	dence 6 (Other (S)	oecify)
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre y)	et, factory, office		28f. Location (. City or To	Street and Number or wn, State)	Rural Route Number,
	To the Hospital or within 24 hours afte within 24 hours afte Completely filled in the completely filled in the completely filled in the completely filled in the completely filled in the completely filled in the complete completely filled in the complete completely filled in the complete completely filled in the complete completely filled in the complete completely filled in the complete completely filled in the complete completely filled in the completely filled in t	edical (29a. Certifier (Check only one) 1 Certifying Phy	vsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tirestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of conflier	we Mi		29c. Licens		(29d. Date signed (Ma	
(1	grote		30. Name and address of person who con the second s				1237274	A jand	10/0/0/0/0	>
	Sta Registr		31. Date filed (Month, Day, Year) FEB 13	32. Registra Signa	ature	Coxes)				

			1 - For State Registrar	State of Ma		partment of He ertificate of D		ental Hygie Reg.	711116	05989
	Physici	an	1. Decedent's Name (First, Middle,	Last)				Date of Death Month	Day Year	3. Time of Death
1	/Medic	al	4a. Facility Name (If not institution,	- WW	7	4b. City, Town, or	Location of Death	Fubracy	4c. County of Dear	h /2 C5/3 W
م	Examin	ier	4a. Facility Name (if not institution, s	His eh to	al a	Rabbe	fic In-	úa.	Belt	1. A. X. P.
	Funeral		5. Social Security Number 6	. Sex 7. Age	e (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Biri	hplace (State or Foreign
П	Director		073-32-9668	1∭ M 2□ F	93 Yrs.		Δ.	pril 7,1	912 New	York, NY
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
:	Mary Inteh	ţō	Maryland Baltim	ore	Baltimor	2				1 ☐ Yes 2 🖾 No
	or 282	Directo	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	ath w	rai	3714 Michelle Wa		5	21208	annia Origina (Can		ited Sta	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Depertment of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural; or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? d 177 Yes 2 1		 Was Decedent of His If Yes, specify Cubar Yes 2♥ No 	Specify:	Rican, etc.)	Black, White	e, etc.
	hours tural',	q pe	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	1945	cedent's Usual Occupa	ation	168	. Kind of Business	
5	n "na"	plete	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	(Gi	ve kind of work done of . DO NOT use retired,	during most of workin			,
212	giene giene gritha	Com	Elementary/Secondary (0-12)	5+		tist			Dentist	У
g	be file tal Hy d oth	Be	17. Father's Name (First, Middle, La	ist)			18. Mother's Name		den Sumame)	
<u>₹</u>	d Men narke	2	Harry Turer 19a. Informant's Name/Relationshi	n (Tuna Print)	19h Ma	iling Address (Street a	Esther F		ity or Town State	Zin Codel
Na	d 2 st th and th and traum		Paul Turer - So			MIchelle	200	imore, MI		
Baltimore, Maryland 21215-0036	The Hear		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3			position (Name of rematory or other place			. Location - City or	Town, State
Ē	t. Pag rtment rtant: njury o		4 Donation 5 Other (Spe	ecîfy)	Beth El	Cemetery 22. Name and Addres		.2006 W	estwood,	N.J.
Ba	Depermine Depe		21. Signature of Funeral Service	We	M00956 I	Subin Memor 5120 Jog R	rial Chape	el Beach	EI 33///	
			23a. Part 1. Enter the disease, or c shock, or heart failure. List or	omplications that caused	the death. Do not	enter the mode of dying	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between
1	Physician		fmmediate Cause (Final disease or condition	ر کیدر)	-5 S					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Understrip Cause (Disease or injury	b. Die to (or as	a consequence of):					
	cuted	Examiner	that initiated events	c						
ő,	cate be executed bhysician end the burial-transit		resulting in death) Last							
38760,	death certificate be executed e ettending physician end id for use as the burial-transit	dlcal		d						
Вох 6	leath certific ettending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		2 Oc.			23d. Date of de	livery
o. B	he death the ette shed for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnant at 9⊟ Unknown		3 ∐Ectopic pregnancy 5 ☐ Other (specify)		anount pro-	Month	Day Year
, P.O	law requires thet the de es been signed by the e 2 should be detached t	by Ph	Part II. Other significant condition	s contributing to death t	out not resulting in the	underlying cause give	en in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
rds	w requires been sign should be							1 🗆 Yes	2 № 3 P	robably 4 Unknown
Records,	law reques been 2 should	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
_	The I	Con						performe 1 ☐ Yes 2	d? death? No 1 ☐ Ye	s 2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	0 T 5 B 10	Othi	er: 4 Date of Death		- 6 COher /6-	20/64
of o	ding Phys After this funeral di	on: To	1 ☐ Yes 2 ☒ No 27. Manner of eath 1 ☒ Natural 5 ☐ Pending	28a. Cate of Inju (Month, Da	ury 28b. Time	e of 28c. Injury	y at k?	28d. Describe how	e 6 □Other (Spaninjury occurred	9CITY)
Division	Attender deeth ector: by the	Certification;	2 Accident investigated as a Suicide 6 Could not determine the could not determine the could not be compared to the could not be com	ot be 28e. Place of In	jury - At home, farm, tc. (Specify)		Yes 2 □No	28f. Location (Stree City or Town, S		tural Route Number,
ā	~ C	Cer				AME OF THE RESIDENCE OF THE SECOND		company of the company	1845 pp. 6 pt. page 2	
	To the Hospital within 24 hours e To the Funeral I completely filled	dical	(Check only 2 Medical E	Physician: To the best examiner: On the basis of and manner st	of examination and/o	r investigation, in my o	pinion, death occurr	ed at the time, date	and place, and du	e to the cause(s)
2050,0	To the Mithin To the	Me	29b. Signature and title of certifier			29c. License	e number	29d	Date signed (Mon	th, Day, Year)
	+1		Alis -	High	/	114.	3974	Ti	brans	P. 2006
Co	3		30. Name and address of person w	no completed cause of	death (Item 23a) (Ty	oe, Print)	W. A.	. Nove	1.	m. P. H
1	C	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	1750	V- Ken	vot CVCV	Walter J. B.	land
	Regist		FEB 13	2006	JA A	Sec.				

		1 - For State Registrar	State of Maryla				Death	aria ivi		eg. Ño.	16	05990
7 4 5	<i>4</i> 0-	1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
Physic		Herman Lee Tay	lor, Sr.						Februa			12:25 P M
/Medi Exami		4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or	Location o	f Death		4c. Cour	nty of Death	
xaiiii		Montgomery Hospid	ce- Casey Hou	ıse	Ro	ckvi	lle			Mor	ntgome	ery
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Unde Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign
Director		051-12-6684]M 2□F	92 Yrs.	MOUTHIS	Days	Tiodis		Jan. 5,	1914		exas
D.		Usual Residence of Decedent	140 -									104 1-14- 0:11-1-
how	_	10a. State 10b. County		City, Town or Lo								10d. Inside City Limits M☐ Yes 2☐ No
e Ma	cto	Maryland Montgome:	ry S	Silver	Sprir	ng						
within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23s or 28s-f ehow he Madical Examiner must be notified at	Funeral Director	10e. Street and Number			10f. Zi	p Code				l0g. Citizen o	of What Cou	intry?
23a	a	9039 Sligo Creek	Parkway, #303	3		2090	1				JSA	
r dea	Inei	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Dece If Yes, spe	edent of Hi	ispanic Orig n, Mexican	gin? (Spe i, Puerto f	cify Yes or No- Rican, etc.)	14. F	ace - Amer lack, White	
id within 72 hours after giene. er than "naturel", or it is Madical Examin	Ŧ	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐ x No If Yes, Give		1 🗆 Yes		Specify:				cify: Bla	nck
ours	d by	3 □ Widowed 4 🙀 Divorced	Year or Dates:									
72 h natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	16a. Dece (Give	dent's Usu kind of w	ual Occupa	ation du <i>ring m</i> ost I)	t of workir	ng	16b. Kind of		ŕ
iffin	Idu	Elementary/Secondary (0-12)	College (1-4or 5+)				"			C.I.A. Dining		
ygier ygier t, th	Ö		4	He	ad Cl	nef			(F) . A			1
id 2 should be filk th and Mental Hy 27 is marked oth traumatic event	Be	17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden Sum	ame)	
Ment	2	Emmitt Taylor					на	ttle	Allen			
sho and and se ma		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailie	ng Addres	s (Street a	and Numbe	er or Rura	l Route Numbe	r, City or Tov	vn, State, Zi	ip Code)
and salth		Herman Lee Taylor		17505	Cour	ntry	View		Ashton			
of He		20a. Method of Disposition	20b.	Place of Dispo cemetery, crei	osition (Na matory or	ame of other plac	e) F		ary 11,	20c. Locatio	n - City or T	own, State
permit. Pages 1 ar Department of Hea Important: If Item eny Injury pr othe		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	ternoval from State	rbeck I				20	06	Olney	, Mary	yland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Iteme 23a or 28a-1 show eny fully or other traumatic event, the Medical Examiner must be notified at once.	1 7	21. Signature of Funeral Service Licens		20	2. Name a	nd Addres	ss of Facilit	y	Eurosa 7	Homo	Tna	
Ded dring		John Collins	1984	5	rancı UU Uı	ilver	sity	Blvd	, W, Si	lver 5	orine	, MD 20901
TO SEE		23a. Part1. Enter the disease, or compl	ications the caused the de									Approximate
		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.									Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Non-Hodgkir		homa							
Examiner			Due to (or as a conse	equence of):								
7.3	١.	Sequentially list conditions,	Due to for as a cons									
sit ad	ine	Sequentially list conditions, if any leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to for as a cons	mence or :							- 1	
be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last		annon of):							_	
e exc ien a urial	<u> </u>	reserving in dealing case	Due to (or as a conse	equence or):								
ate b hysic	Ical		d									
certifical Iding physee as th	Jed	IF FEMALE:										
th ce endi	2	23b. Was decedent pregnant	3c. If yes, outcome of preg 1☐Live birth 2☐Fe		Ectopic	pregnancy					Date of deli	
deal	ic is	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at time of 9 Unknown		Other (s						Month	Day Year
t the by th	hys	9 Unknown	9 Offictiowit				_					
The law requires that the death certificate be executed the has been signed by the ettending physicien and lage 2 should be detached for use as the burial-transit	by Physician/Med	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	inderlying	cause giv	en in Part I.		23e. Did to	bacco use c	ontribute to	the cause of death?
he law requires t e has been signe age 2 should be	D D								1 □ Y	es 2. K∑No	3 ☐ Pro	bably 4 Unknown
A red bee	Completed								24a. Was	an 24	b. Were au	topsy findings available
has pe 2	ם								autop	sy	prior to death?	ompletion of cause of
									1 ☐ Yes		1 🗆 Yes	2□ No
Physician: The law r this certificete has b ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		_	Oth	0.5		Check only o			
Physician: T r this certificet and director, pa	ို	1 195 2 X NO	1 Unpatient 2				4 🗆 Nu					n/y)Hospice
E = = = = = = = = = = = = = = = = = = =	i.	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injur Wor			28d. Describe h	ow injury oc	curred	
ending sath. or: After he funer	ati	2 Accident investigation			М		Yes 2 🗆	No				
er de	I≝	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st	reet, facto	ry, office		1	28f. Location (S City or Tow	itreet and Nu n, State)	mber or Ru	ral Route Number,
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Certification;		3, 111, (300									
Hospitel	le		sician: To the best of my k									
1 24 10 Fu	D D	one) 2 Medical Exami	ner: On the basis of exami and manner stated.	nation and/or in	ivestigatio	on, in my o	pinion, dea	ith occurr	ed at the time, o	tate and plac	e, and due	to the cause(s)
To th To th comp	Me	29b. Signature and title of dertifier			2	9c. Licens					_	, Day, Year)
->- 0 M) \ H\/.	\wedge	WIL		D	35635	5		Febru	ary 7	' , 2006
100				, ,)								
12		30 Name and address of parent who o	ompleted cause of death /it	em 23a) /Tune	Print)							
12		30. Name and address of person who co Joseph Kaplan, M.				Road	, Roc	kvil	le, MD	20855		
12	tate	30. Name and address of person who co Joseph Kaplan, M. 31. Date filed (Month, Day, Year)		caster			, Roc	kvil	le, MD	20855		

		1 For State Registrar	State of Marylar		artment of I		d Mental Hy	giene () Reg. No.	06	05991
₹	21	Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
Physic /Medi		Gertrud	Volkmer				Febru	arv 13	2006	7:10 A M
Exami		4a. Fecility Name (If not institution, give s			4b. City, Town,	or Location of D			nty of Death	7.10 A
- A		Cherry Lane Nursin	g Home		Laurel			Pri	nce Ge	orge
Funeral		Social Security Number 6. Sex		last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Bir (Month, Da			oleca (State or Foreign
Director		217 43 9922	M 2⊠F 83	Yrs.	INGHING Cays	110010	Jan 23	, 1923		many
pus *		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	ecation					0d. Inside City Limits
anyla sho	2									1 ☐ Yes 21X No
he N	ect	MD Howard 10e. Street and Number	Co	lumbia				10 00	1112	
with B or	급	6903 Greenleigh Dr	iro		10f. Zip Code	_		10g. Citizen		ntry ?
ING 21213-0035 be filed within 72 hours after death with the Maryland hat Hygiene. Id Hygiene. Id other then "natural", or items 23a or 28a-f show event, it a Medical Examinar must be notified at	Funeral Director		12. Was Decedent Ever in U	S 123	2104		/Canaity Van as Na	Germ	any Race - Americ	an Indian
ter d	i.	11. Marital Status 1 Never Married 2 Married	Armed Forces?		f Yes, specify Cut	oan, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	14. 5	Black, White,	
0036 hours after tural', or its	by F	3 □Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 🎉 No	Specify:		Spe	city:	ite
Z1Z15-0036 d within 72 hours afgiene prithen "natural", or the Medical Exam	ed	15. Decedent's Educ		16a. Deced	dent's Usual Occu	pation		16b. Kind of	f Business/Inc	
d 21215- filed within 72 Hygiene. ither then *nai	Completed	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	during most of	working			200)
A the second	Eo	Elementary/Secondary (0-12)	College (1-4or 5+)	Home	emaker			Ox	vn Home	Δ
Hygin other	a	17. Father's Name (First, Middle, Last)				18. Mother's i	Name (First, Middle			-
	To B	Franz Johann Babis	ch			Anna C	lara Ogora	solka		
E SPEE	-	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	ng Address (Street		Rural Route Numb		vn, State, Zip	Code)
Mar nd 2 sho nlith and 27 is m r traum		Ingrid Miller/Daugh	nter	6903	Greenle	igh Driv	ve Columb	ia MD	21046	
ore, Ma es 1 and 2 of Health a of Health a litem 27 is		20a. Method of Disposition	20b. F	lace of Dispo	sition (Name of natory or other pla		Date	-	n - City or To	own, State
Pages nent of land: If Its		1 Burial 2 Cremation 3 R '4 Donation 5 Other (Specify)	emoval from State		dge Ceme		16-2006	Elkrid	are Mi	
트 교원론을 .		21. Signature of Funeral Service License								ly FH Inc.
Department of the partment of		> Stem Collan	- cut he				arry n. w. a Pike Ell			
		23a. Part1. Enter the disease, or complic	cations that caused the deat						CILLY,	Approximate
n new constraint	١,,,	shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.							Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Alzheime		Disease					10 yrs
Examiner			Due to (or as a conseq	uence or):						-
N STA	<u>6</u>	Sequentially list conditions, b	Due to for as a sonsay	aanca off:						
nsit	Examiner	ir any, toacing to immediate cause. Enter Underlying Cause (Disease or injury								
ou, be executed ician and burial-transit	xa	that initiated events cresulting in death) Last	Due to (or as a conseq	uence of):						
od / ou, icate be executed physician and sthe burial-transit	dical E									
certificate ding physise as the	edic		-							
BOX Defeated the second	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of pregna					234 1	Date of delive	arv.
death death	clar	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d		Ectopic pregnanc Other (specify)	У				Day Year
check the c	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown							
ords, F.C. requires that the		Part II. Other significant conditions con-	tributing to death but not res	ulting in the ur	nderlying cause giv	ven in Part I.	23e. Did to	obacco use co	ontribute to th	e cause of death?
uires that is signed to the det	d by						10	res 2. ▼No	3 Prob	ably 4 Unknown
w requires been sign	eted						24a. Was			- Alexine a suritable
has has	dmo						– lautop		prior to con death?	psy findings available npletion of cause of
	O	(1 ☐ Yes	2 No		3 € No
Or VICA Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		0#	har	Death (Check only o			
Phys this	၉	1 Yes 2 No	1 Inpatient 2 28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA	4X Nursing	Home 5 Resid			"
After fune	loi	1 XNatural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injui Wo M 1		28d. Describe h	low injury occ	urrea	
or Attending I after death. Director: After in by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be	One Diego of Joines, At he			Yes 2 □ No	204 Leasting /	Conned and Advis	mhar ar Over	(Court Months
or A after Direct in by	artif	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif)	me, raim, stre	et, factory, office		City or Tox	n, State)	nder or Hural	l Route Number,
To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 N Certifying Physi	Inione To the head of	dada						
Hos 24 hc Fun itely i	edical	(Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wiedge, death tion and/or inv	occurred at the tile restigation, in my o	me, date and pla opinion, death oc	sce, and due to the courred at the time,	cause(s) and i date and place	manner as sta e, and due to	ated. the cause(s)
thin ;	Med	29b. Signature and the of certifier	and marrier stated.		29c. Licens	se number		29d. Date sign	ned (Month I	Day Year)
F 3 F 8		11	1/2 MD			4488				
		Lennel	140							3, 2006
002			mpleted cause of death (Item	23a) (Type, I	Crru L	ane. La	aurel, n	OA.	2070	7
/*		31. Date filed (Month, Day, Year)	32. Registrar's Signa			, ,	1 / /		- , 0	
Sta Registr		ST. Date filed (Month, Day, Year)	oz. riegistrar s signa	ui e						

State of Maryland / Department of Health and Mental Hygiene 05992 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death Year Day **Physician** Whittington Marv 2 12 2010 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 509 Booth Street Salisbury Wicomico Months Days Hours Min. Jan. 8, 2194 6 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 K F 60 Maryland Yrs. Director 218-48-6495 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show 1 AYes 2 No Maryland Wicomico Salisbury Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 509 Booth Street 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status the Medical Exeminer Pages 1 and 2 should be filed within 72 hours after nent of Heelth end Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Wicomico County Board Ith end Mental Hygiene. 27 Is marked other than 'r traumatic event, the Mar then College (1-4or 5+) Elementary/Secondary (0-12) teacher of Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alexander Collins Samuel Hester ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 2780 Hickman Lane - Nanticoke, Maryland 21840 Phyllis Hardy/cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Depertment of Important: If eny injury or once. 4 ☐ Donation _ 5 ☐ Other (Specify) Springhill Mem. Gdns 02/21/2006 Hebron, Maryland 21. Signature of Furieral Service Licenses 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21801 JOLLEY MEMORIAL CHAPEL 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. . Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Saque fiely list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires thet the death certificate be executed burial-transit sser resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician s the burial Completed by Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No After this certific funeral director. 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred s after decreal Director; After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Direcompletely filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated To the 29b. Signature and title of certifier 29c. Ocense number 29d. Date signed (Month, Day, Year) h (Item 23a) (Type, Print) 30. Name and address of person who completed cause of DINGI ~~ ナ・ム 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 2006 Registrar

			1-	For , State Registrar		e of M	aryland		artmen rtificat			and M	lental Hy	gien Reg. N		05993
	Physic			Decedent's Name <i>(First, Middl</i> Donald Philip		s, Sr							2. Date of De Month Februar	_	Ĩ, 2008	3. Time of Death 1:00 p M
	/Medi Examii		6	Facility Name (If not institution 5 Woods Way	n, give street an	d number)				Town, or	Location o			40	c. County of Death	
	Funeral Director		22	Social Security Number 0-24-2011 ual Residence of Decedent	6. Sex 1 🔀 M 2 □	7. Ag	ge (In yrs. Ia 75	est birthday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da March 2	th 18, Year 28, I	9. Birth 930 Mary	place (State or Foreign otry) Land
	e Maryland a-f show	ctor	10	a. State 10b. County			10c. City, E1kt	, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with th	ai Dire		e. Street and Number 65 Woods Way					10f. Zip	Code 921					itizen of What Cou	-
9800	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be collided at	d by Funeral Director	11.	Marital Status 1 □ Never Married 2√2 Marria 3 □ Widowed 4 □ Divorced	ied 1 🗆 Y	Decedent d Forces? es 2 (1) d, Give A or Dates:	Ever in U.S No	'	Was Deced f Yes, spec 1 ☐ Yes	77	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.))-	14. Race - Ameri Black, White, Specify: Whi	etc.
21215-0036	- 2	Completed		15. Deceden (Specify only highe: Elementary/Secondary (0-12)		<i>ted)</i> ge (1-4or 5	5+)	16a. Deced (Give life. L Insur	kind of wor DO NDT us	rk done d e retired,	uring most)		ng	16b. F	Kind of Business/Ir Insura	,
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the M	To Be C		Father's Name (First, Middle, Harry Osborne	Walters						Cla	ara ((First, Middle, Capetz		n Sumame)	
Baltimore, Mary	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the MODE.		L 208	a. Informant's Name/Relations Orraine Walter a. Method of Disposition 1 Aburial 2 Cremation 2 Donation 5 Other (S	s/wife 3 □Removal fi		Cel	65 Wo ace of Dispo metery, cren Holy netery	ods W sition (Nam natory or of Rede . Name and	lay, ne of ther place emer d Addres	E1kto	on, Mohrua 2006 Crow	Marylan ary 15,	d 2: 20c. L Bal	ocation - City or To 1 timore, 1 Home	
8760,	/Medical Examiner	dicai Examiner	Se car	a. Part1. Enter the disease, or shock, or heart failure. List mediate Cause (Final lease or condition sulting in death) quentially list conditions, the landing to immediate use. Enter Underlying use (Disease or injury it initiated events ulting in death) Last	ab. cd	e to (or as	a conseque	ence of):	er the mode	e of dying	such as c	rardiac o	r respiratory and	rrest,	. 1	Approximate Interval Batween Onset and Death O
P.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Medical		FEMALE: b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 □ Li 4 □ P	ve birth	of pregnance 2 Fetal d time of dea	leath 3	Ectopic pre Other (spe						23d. Date of delive Month	ery Day Year
Division of Vital Records, P.	or Attending Physician: The law requires fiter death. Director: After this certificate has been sign in by the funeral director, page 2 should be	Certification: To Be Completed by	25.	Was case referred to medical examiner? 1	Hospital: 28a. D gation not be ined 28e. P	Inpatie ate of Injunidonth, Day	20 july 2 Ellipy Year) 2 ury - At home 2. (Specify)	P/Outpatient 28b. Time of Injury	3 DO/	A Other	26. Place of 4 Nursaat ops 2 N	sing Hom 2	24a. Was autor performed to the control of the cont	an psy med? 222 No me) dence now injured.	24b. Were autoprior to cook death? 1 Yes 6 Other (Specify occurred	psy findings available mpletion of cause of 2 No
	To the Hospital within 24 hours a To the Funeral completely filled	Medical		one)	Examiner: On the	the best one basis of nanner sta	examinatio	ledge, death on and/or inv	estigation.	in my opi	nion, death	place, a occurre	d at the time, o	date and) and manner as st d place, and due to	the cause(s)
)	To with	-		Signature and title of certifier	lel./C	if a	P-1	20-2	2	License 2	number 23	7			te signed (Month.	
	5		~	Name and address of person of ATAIYTILAL	K-197	EL	1239	Sino	rint)	ly	AVE	e,E	ELKT	C74	(m1) 21	1921
	Sta Registr	-		EB 1 4 2006	Beren	2. Hegistra	ar's Signatur	re W								

Physici		Decedent's Name (First, Middle, La David Webst		2. Date of Death Month D	ay Year 3. Time of Dea
/Medi Examir		4a. Fareility Name (If not institution, giv			c. County of Death
_xumm		Peninsula Rec	ional Medical Center Salisbury		Wicomro
uneral		5. Social Security Number 6. S	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Apr. 10 1	9. Birthplace (State or For
rector		219-30-7640 Usual Residence of Decedent	69 Yrs.	Apr. 10 1	936 Maryland
ahow Tal	<u>.</u>	10a. State 10b. County	10c. City, Town or Location		10d. Inside City Li 1 ☐ Yes 2'
id other then "naturel", or items 23a or 28a-f ehow event, the Madical Examinar must be notified at	Funeral Director	Maryland Wicon		10- 6	itizen of What Country?
a or	급	10e. Street and Number 6598 Quercus I	rive 21830		U.S.A
ms 2:	Jera	11. Marital Status	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp		14. Race - American Indian,
e e	Full	1 ☐ Never Married 2 Married	1 Myes 2 □ No	Hican, etc.)	Black, White, etc.
Exa	d by	3 Widowed 4 Divorced	Year or Dates: 59-62	10	Black
nation	Completed	15. Decedent's E (Specify only highest gra	de completed) (Give kind of work done during most of work life. DO NOT use retired)	aing 16b.	Kind of Business/Industry
The	E	Elementary/Secondary (0-12)	College (1-40r5+) 5+ Teacher	E	ducation
vent, I	BeC	17. Father's Name (First, Middle, Last	18. Mother's Nam	e (First, Middle, Maide	n Sumame)
marked o	70	Paul E.Waters	Lillia	an Dredde	n
7 is marke traumatic		19a. Informant's Name/Relationship (
item 27 other t		Ella M. Waters 20a. Method of Disposition			1830 Location - City or Town, State
≠ 5		1 25 urial 2 ☐ Cremation 3 ☐	Removal from State cemetery, crematory or other place)	2/11/	
mportant: any injury once.		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lices	and the same of th		ebron,Md.
Importa any inju once.		Hladys B.	5 Stewart Funeral	Home isburv.Mo	1.21801
-			plications that caused the death. Do not enter the mode of dying, such as cardiac		Approximate Interval Between
sician		Immediate Cause (Final disease or condition	Sersis		Once and Dea
edical		resulting in death)	a. Due to (or as a consequence of):		100
miner		Sequentially list conditions,	b. wound unjection	1	- Cont
ısit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Diabetes Mellitus	1 1/6	SAI EXAMINER
siclen and burial-transit	Examin	that initiated events resulting in death) Last	C.	WINDS MO	W Even
> w	cal		d.	ON APPROVED S. M.	
ettending phy I for use as th		IF FEMALE:	CEKIN		
ttendi or use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
by the e	/sic	1 Yes 2 No	4☐ Pregnant at time of death 5☐ Other (specify)9☐ Unknown		
D B		-	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of deat
5.6	d by		End-style Kidey Fail	1 ☐ Yes	2 No 3 Probably 4 Unk
should should	Completed		Sould and Dung 2016	24a. Wasan	24b. Were autopsy findings ava
page 2	E O		So real Carrier and Carrier an	autopsy performed? 1 ☐ Yes 2 🔀 N	prior to completion of caus death? 1 ☐ Yes 2 ☐ No
certificete rector, pag	8	25. Was case referred to medical	26. Place of Deat	h (Check only one)	0 10103 2010
<u>v</u> :5	To B	examiner? 1 XYes 2XX No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 🗆 Residence	6 ☐Other (Specify)
ofter thus		27. Man or of Death 1 ☐ Natural 5 ☐ Pending	(Month, Day Year) Injury Work?	28d. Describe how inju	ury occurred
the fi	Certification:	2 Accident investigation 3 Suicide 6 Could not b		29f Loostion (Street	and Number or Ours Courts Number
Direc in by	art I	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, Sta	ind Number or Rural Route Number, te)
To the Funeral Director: After completely filled in by the funer		29a. Certifier Certifying Fr	ysician. To the best of my knowledge, death accumed at the time, date and place,	and due to the causal	s) and warner as stated.
e Fur	edical	(Check only 2 Medical Exar	iner: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.	red at the time, date ar	nd place, and due to the cause(s)
To the	×	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
		Cu Valle V	(gn w-V) D16725		2/2/00
28		0	1 110/20		

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 7, 2006 3:17 P M February Jacob Zwirn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Bowie Health Center Bowie If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days 1**X**M 2□F Yrs June 5,1924 New York Director 087-18-0504 81 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f ahov the Medical Examiner must be notified at 1 ☐ Yes 2X No Crofton Maryland | Anne Arundel Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 238 2114 USA 1304 Persimmontree Ct. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1944–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government years Attorney other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental F Pages 1 and 2 should be nent of Health and Mental Int: If Item 27 is marked o Rose Lichenfeld Morris Zwirn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1304 Persimmontree Ct., Crofton, MD 21114 Marie Zwirn/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ■ Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment of Importent: If any injury or once. 2-10-06 Crownsville, MD MD Veterans Cemetery 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee alle 2973 Solomons Island Rd. Edgewater, MD 21037 aucuto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No within 24 hours after death.

To tha Funeral Diractor: After this certific completely filled in by the funeral director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 ER/Outpatient 1 Tes 2 No 1 🗌 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ddress of death (Item 23a) (Type, Print) 6201 DEDOWAL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 0 2006 Registrar

			1 - For State Registrar	State of Ma	ryland	d / Departme <i>Certific</i>			Mental F	lygier Reg. r	4000	05997
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, La. THOMAS AND 4a. Facility Name (If not institution, giv.	ERSON		4b. C	ity, Town, o	r Location of Deat	2. Date of Month February	0 م رنان	Day Year 27 '200 (sc. County of Dea	
	Funeral Director		5. Social Security Number 6. S 228-30-2242 1 Usual Residence of Decedent	DIM OFF	L (In yrs. 12 76	ast birthday) If Un Montl	and of der 1 Year hs Days	If Under 24 Hrs Hours Min.	8. Date of (Month, August	Birth Day, Yea	9. Bir	more thinglace (State or Foreign ountry) ginia
	anyland show	_	10a. State 10b. County		10c. City	, Town or Location						10d. Inside City Limits 1 XYes 2 No
	the Ma	ecto	MD NA 10e. Street and Number			Baltimo:	re Zip Code		· · · · · · · · · · · · · · · · · · ·	10g. 0	Citizen of What C	
	h with	ID IE	3800 Belvedere Avenu	e Apt 207			212	215			USA	,
036	i within 72 hours efter deeth with the Maryland liene. r than "natural", or items 23a or 28s-1 ehow the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:				lispanic Origin? (S an, Mexican, Puerl Specity:	pecify Yes or o Rican, etc.)	No-	14. Race - Ame Black, Whi Specify: Black	te, etc.
21215-0036	within 72 ene. than "na he Medic	Completed by	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)		-)	life. DO NO	work done	during most of wo	rking		Kind of Business Trucking	
Maryland 2	be filed hta! Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last) Thomas Anderso					18. Mother's Nar	ne (First, Mide mey Ande		en Sumame)	
Mar	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Ruth Anderson/ Wife	Type, Print)		19b. Mailing Addr		and Number or Ru Park Aver				Zip Code)
	of Heal		20a. Method of Disposition		20b. Pla	ace of Disposition (in metery, crematory)	Name of	1	Date		Location - City or	Town, State
Baltimore,	000-		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Garr	ison Forest	Vetera	an Cem. 03-	-0806	Owi	ngs Mills	, MD
Balt	permit. Pag Depertment Important: i any injury o		21. Signature of Funeral Service Licer	mes				ss of Facility L Home 638	N. Gilmo	or St.	Balto, M	21217
1	Ate be executed hysician and hysician and Examiner in be being in the burgar fransit	Ical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line	consequ	ARR ence of): ATORY ence of): Shock		- -	, or respiratory	, and st,		Approximate Interval Between Onset and Peath
P.O. Box 68	death certific e ettending p id for use as f	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at Ii 9 ☐ Unknown	Fetal	death 3 ☐Ectopic	c pregnancy (specify)				23d. Date of de Month	livery Day Year
	w requires that the sbeen signed by th should be detache	þ	Part II. Other significant conditions of	_	-		ig cause giv	en in Part I.		d tobacco		o the cause of death?
corc	> 11 0	Completed	TM	ENTITU		LURE			24a. W			utopsy findings available
Re	ela Pesson	ошо							au	topsy normed?	prior to death?	completion of cause of
/ita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Un andrelle				26. Ptace of Dea	- 1			
of	Phys this ral dii	7: 10:	1 Tes 2 No	Hospital: 1 Impalient		R/Outpatient 3 28b. Time of	DOA Oth	4 LI Nursing H			6 ☐ Other (Spe	cify)
É	or Attending Pheefer death. Director: After this in by the funeral.	Certification:	1 Patural 5 Pending 2 Acciden investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (n (Street and Number or Rural Route Number, Town, State)		
_	2 Accident and Street and Place and									ne cause(e, date a	s) and manner as nd place, and due	s stated. e to the cause(s)
	To the	Me	29b. Signature and title of certifier.	Λ. Λ			29c. Licens				ate signed (Mont	
			Johngo	- M.D			Doo	63322		Tel	Illary 12	1,2006
(30. Name and address of person who.	completed cause of dea	ath (Item	23a) (Type, Print)					~	
	Sta Registr		31. Date filed (Month, Day, Year) MAR (1 1 2)	32. Abgistrar	's Signati	ure South						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#20b, 20c, perHI, 0853, 3/3/06 TI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3ROWN 26. EB ANDI 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE KITCHIE HOSPICE TOSEPH If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 709 1**⊠**M 2□F MARCH 04, 1935 245-56-Yrs. NORTH CAROUNA **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avent, the Madical Examinar must be political at 1XYes 2 ☐ No Directo MARYLAND 10g. Citizen of What Country? 10e. Street and Number ō STREET USA 238 50 STON Funerai death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status e filed within 72 hours after if Hygiene. other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Narried Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: BLAC 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 THGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Health and Mental HENRI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BROWN ST. APT223 GLENDA BALTO, MD 21202 WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt., Zion Cemetery Tem 20c. Location - City or Town, State 20a. Method of Disposition ō = 6 1 Burial 2 Cremation 3 Removal from State Lansdowne, MD Depertment of Important: If any Injury or 4 Donation 6 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee JR, FUNERAL HOME FULTON AVE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years Physician cancer 01 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Brown as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Day 4 Pregnant at time of death 5 Other (specify) signed by the al 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 ☐ Probably 4 Donknown pancreatitis 1 Tes 2 🗆 No page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes autopsy performed 2 No 1 Yes Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HTSpice 1 ☐ Yes 2 Z No Medicai Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Japitat v. 4 hours efter dean. 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D24170 February 27, 2006 Tr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 838 N. Eutaw St Bultimore Richey Hospice 150 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0

Amend Trem 6 per In 8353 3-1-06 vt Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** BRISCOE 6:35 SARAH FLETCHER 23 2006 February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NA Agnes thospital Baltimore Daint If Under 1 Year | If Under 24 Hrs. 8. Date of 8 (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1 □ M 2 🛱 F 217.20.9185 98 Yrs. Director 10.19.20 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show rthan "natural", or itema 23a or 28a-f shov the Medical Examinational be notified at 1 ☐ Yes 2 No MD BALTIMORE ARBUTUS Direct 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1108 SULPHUR SPRING ROAD 21227 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 **⊠**No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or It any injury or other traumatic event, the Medical Exercitiva 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify Specify: ð BLACK 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) WESTERN ELECTRIC FACTORY PRODUCTION 12/14 GRADE NIA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) SNOWDEN FLETCHER MARY CROWLLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (DAUGHTER) DOROTHY BRISCOE 1108 SULPHUR SPRING RD ARBUTUS. MD 21227 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State ARBUTUS 03.01.06 BALTIMORE, MO * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune(al Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE anshr 5151 BAUTO. NATE PIKE, BAUTO. MU 21229 23a. Part1. Enter we disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary Embolism **Physician** days /Medical Due to (or as a consequence)of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the burial-transit and Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X lo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has director, page 2 autopsy performed? 2 No 1 ☐ Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Injury at Work? il or Attending Patter death. Certification; 1 Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated within 2 To the J 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Records.

Division of Vital

31. Date filed (Month, Day, Year) 0

JEORGE

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DURST

32. Registrar's Signature

1120 N. Relling

ass 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0059914

Baltimore

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Maryland

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